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ABSTRACT

This document reports a revision study of the California Alcohol Services Reporting System (ASRS), a system which consists of a structure of definitions and categories of services, a budget form of planned alcohol services, instructions for the county plan, and the report of expenditures. The study problem is that the ASRS structure of definitions, categories and forms may be too restrictive and inadequate to accurately reflect the current diversity of publicly funded alcohol programs and services in California. The study methodology consisted of a literature review and site visits to and interviews with purposive samples of county alcohol programs and local service providers. Selective characteristics of the county alcohol programs and of the local service providers that were visited are described. The diversity of models of service in publicly funded programs is discussed. Six issues regarding the County Alcohol Program Administrators' use and evaluation of components of the ASRS are discussed. These include overall use; problems with direct and indirect categories of service, with "participant" and "visit" types of service recipients, and with budget forms and cost guidelines; services that do not fit the ASRS subcategories; and special accomplishments that are inadequately noted. The kinds of inadequacies in the data from the ASRS and selected emerging issues that might impact revision of the ASRS are discussed. Six major recommendations are presented with their rationales. The appendices include study plan and methods, a glossary, a paper on alcohol services models, and a discussion of the community-social model philosophy. (ABL)

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THE ALCOHOL SERVICES REPORTING SYSTEM (ASRS) REVISION STUDY

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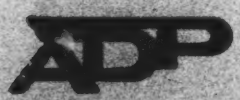

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THE ALCOHOL SERVICES REPORTING SYSTEM (ASRS)

REVISION STUDY

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August 15, 1986

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EXECUTIVE SUMMARY OF THE STUDY AND ITS RECOMMENDATIONS

The problem for this study was to examine what revisions, if any, the Alcohol Services Reporting System (ASRS) may need to accurately reflect the current diversity of publicly funded alcohol programs and the emerging new services that are developing. The ASRS was thought to be too restrictive and inadequate to reflect the current diversity of programs and philosophies of service. The community-social model philosophy was thought to be violated by the structure of ASRS categories and definitions that are medical or clinical in orientation.

The Department of Alcohol and Drug Programs (DADP) had previously changed the reporting systems in 1974 and in 1980 when the ASRS was adopted. These revisions included input from the CAPA's and providers and were responses to criticisms of the reporting system from the alcohol field.

An ASRS Committee was appointed by the Division of Alcohol Programs. I was hired as an independent consultant to do a study of county alcohol programs and service providers regarding ASRS issues. The study plan involved site visits and interviews with staff in a purposive sample of county alcohol programs and a purposive sample of local service providers. The samples purposefully selected diversity among counties and among programs. Fifteen counties were studied; 64 local programs were visited.

The findings are presented in terms of three major questions:

1. What is the diversity of models of service and actual services found in publicly funded programs in California?
2. How do the county alcohol programs use and evaluate the ASRS?
3. How adequate are the current data from the ASRS for the oversight and information needs of the state Department of Alcohol and Drug Programs and the legislature?

The data analysis showed that there is a wide range of diversity of models of service and actual services in programs that include: community-social model, clinical, hybrids, and quasi-medical. Almost all programs visited were nonmedical.

The use and evaluation of the ASRS depends on the type of county alcohol program (CAP). In general, small counties with combined alcohol and drug administrations and clinical philosophies clustered as one type. Two other types were: medium or large counties with alcohol-only administrators who were either commmunity-social or eclectic in philosophical orientation. The political and bureaucratic environments for these types varied

significantly. These factors affected the use and evaluation of the ASRS. In general, the latter types were more affected by the ASRS than small counties with combined alcohol and drug administration.

Many serious problems were identified with the current ASRS. Many new services cannot be categorized by the existing categories. The categories direct and indirect violate the philosophy of the community-social model since they are medical and clinical in orientation. Many programs (whether clinical, community-social model or hybrid) interpret the service definitions differently, classify the same services into different categories, and classify disparate services into the same category. These and other errors produce many serious inadequacies in the current ASRS data. It needs to be emphasized that these errors occur across clinical, hybrid, quasi-medical and community-social model programs.

Six recommendations are presented to the Division of Alcohol Programs. They are based on the analysis of data and the study findings. Many recommendations correspond with those of the ASRS Committee but they were arrived at independently. The recommendations are:

1. Separate the services, units of service and costs-per-bed-day from the county alcohol budget. Accept the simplified budget proposal developed by the ASRS Committee.

Rationale: Bundling together the program cost data and units of service for each service category contributes to invalid, inadequate data, encourages "game playing" by County Alcohol Program Administrators (CAPA's) who have inadequate service categories by which to classify their services, and restricts planning and program development.

2. Develop an alternative procedure (to the ASRS) for collecting information on estimates of the number of people receiving various services (perhaps a state-wide point prevalence study). The units of service (participants, visits and bed days) need to be revised and made comparable for such a study. The alternative procedure should not be linked with the planning or budget process or inadequate data will be generated. The alternative procedure should not intrude on day-to-day program operations for too long. It should be designed by statisticians and experts in sampling and survey methodology to be scientifically adequate.

Rationale: The current units of service are too limited and are not comparable. The current structure provides data on only those participating in "direct" services and is therefore a serious undercount of all service recipients.

3. Develop a cafeteria list of services or activities to substitute for the current ASRS categories. Eliminate totally the direct and indirect categories.

Rationale: A large number of alcohol services cannot be classified by the ASRS categories. They are used by clinical, hybrid, and community-social model programs. The direct and indirect distinctions are interpreted differently and programs classify services incorrectly, producing inadequate data.

4. Develop a procedure for reporting special accomplishments in the narrative section of the county alcohol plan. Encourage counties to report their "success stories" of new services or distinctive achievements.

Rationale: Many counties have accomplishments that cannot be reported by current or planned data systems. Qualitative "success stories" in the County Alcohol Plan (CAP) would provide a vehicle to report and receive credit for program achievements.

5. Develop suggestions for planning service needs for special and underserved populations. Obtain ideas and resources from the special consultants on women, Hispanics and Blacks.

Rationale: Counties are required to present plans for meeting service needs of their special populations but many know little about this. The Division of Alcohol Programs could develop some suggestions that would help counties and improve the quality of information about this issue in the CAP. The special consultants have knowledge that could help the Division of Alcohol Programs with this recommendation.

6. Conduct a special study of the cost guidelines for residential services utilizing trained experts.

Rationale: A large number of issues surrounding the cost guidelines were raised in the study. Staff salaries and benefits are low. Accelerating costs of insurance and real estate make the cost guidelines obsolete and deter the development of new residential facilities. An alternative method of collecting cost-per-day data needs to be developed since the current ASRS data are so invalid and inadequate.

Chapter I

INTRODUCTION

A. PROBLEM

The Alcohol Services Reporting System (ASRS) structure of definitions, categories and forms may be too restrictive and inadequate to reflect the current diversity of publicly funded alcohol programs and services in California. The ASRS may need some revision to accurately reflect the current diversity of alcohol programs and the emerging new services that are developing. Any ASRS revision must respect and take into account: (1) the State DADP's oversight role to insure that the counties are in compliance with the law, and (2) the State DADP, legislature and public's data needs about alcohol programs, services and recipients of services.

B. BACKGROUND TO THE PROBLEM

The current ASRS was developed by the California Department of Alcohol and Drug Programs (DADP) in 1980 to meet statutory requirements to show that county alcohol programs who receive public funds for alcohol services are in compliance with the law. The ASRS consists of a structure of definitions and categories of services, a budget form of planned alcohol services, instructions for the county plan, and the report of expenditures. The ASRS manual includes these items as well as additional supporting information.

Several County Alcohol Program Administrators (CAPA's) who hold the community-social model philosophy of service were especially concerned about the inadequacies of the ASRS. They argued that the major categories of services (direct and indirect) was based on a medical or clinical model of services that was incompatible with and detrimental to the development of community-social model services. There were other complaints as well about related ASRS definitions of participant, participant visit, and other definitions of services that did not fit the reality of programs.

The Chief, Division of Alcohol Programs (hereafter Alcohol Division) convened an ASRS Committee to examine the problem. The Committee's charge was to study the situation and recommend changes in the ASRS as advisor to the Alcohol Division. The Alcohol Division appointed ten members to the Committee including eight CAPA's and two directors of publicly funded alcohol programs. The CAPA's were selected to represent major

kinds of diversity among county alcohol programs in terms of philosophy of service, size of county, etc. The Committee began meeting in March 1985 and continues to meet about quarterly. The Program Management Section (PMS) staff works with the Committee.

The DADP has been responsive historically to criticisms of the reporting system from the alcohol field. Before 1974 the reporting system in use was the Cost Reporting Data Collection (CRDC), taken from mental health. The CRDC was replaced in 1974 by a less restrictive system, the Payment/Cost Reporting System (PCRS), which had been designed with input from the field. Again, in 1980 the DADP substituted the current ASRS for the PCRS. The ASRS had been designed with input from the CAPA's.

C. CONSULTANT ROLE

I was asked to participate as a consultant to the Alcohol Division for a year from June 1985 to June 1986. The consultant was to be an independent outside researcher with no vested interests in the ASRS who was also knowledgeable about the community-social model of alcohol programs and services in California.

The major role of the consultant was to conduct a study of the county alcohol programs and their funded service providers in relation to the ASRS issues. The consultant reported to the Program Management Section of the Alcohol Division. The plan for the study was developed under the guidance and with the approval of PMS staff. From the study's findings, recommendations to revise (or not revise) the ASRS would be developed. The recommendation and their rationale in a final report would then be presented to the DADP, Alcohol Division and the ASRS Committee. In addition, the consultant was to work with the ASRS Committee. The Committee's input about the problems with the ASRS and Committee members suggestions for modifications to the ASRS were sought. The consultant was to advise the Committee on her study findings and recommendations for revising the ASRS.

D. SUMMARY OF THE STUDY PLAN

A brief summary of the study plan and its methods will be described here. A more detailed description of the development and implementation of the study is found in Appendix A. In preparing the study plan, appropriate staff in the Alcohol Division and Division of Administration, State DADP, were interviewed. Pertinent written materials were reviewed.

Four areas of questions were identified in the planning phase as the major foci of the study:

1. What is the diversity of models of service and actual services found in publicly funded programs in California?

2. How do the county alcohol programs use and evaluate the ASRS?

3. How adequate are the current data from the ASRS for the oversight and information needs of the State DADP and the legislature?

4. How might certain emerging issues (such as service needs of special and underserved populations, third party payments, or combining alcohol and drugs into substance abuse) impact on the revisions considered for the ASRS?

The major approach was to collect qualitative data bearing on these questions through site visits and interviews to a purposive sample of county alcohol programs and to a purposive sample of local alcohol service providers funded by those counties. A purposive sample of county alcohol programs would be developed that represented four kinds of diversity in programs. The four kinds of diversity among county programs that might be related to their use and evaluation of the ASRS were: (1) philosophy of preferred model of alcohol services, (2) size of county (population size), (3) type of County Alcohol Program Administrator (alcohol-only or combined alcohol and drugs), and (4) type of service provider (county provider or contracted provider).

In those counties visited, a second purposive sample of alcohol service providers funded by the county alcohol programs would be designed to include diversity in terms of: (1) model of services, (2) type of service (i.e., recovery home, nonresidential services, prevention-education, etc.), (3) some underserved and special population programs, and (4) several emerging newer services that might not fit the ASRS categories.

An interview guide was developed to list the areas of questions and suggested probes for the interviews. Confidentiality was promised to encourage honest open answers. Confidentiality refers to the idea that no one's answers would be revealed by program name, personal name or location.

The preliminary work showed that not all aspects of the ASRS program structure, definitions, categories of service and forms were problematic. Therefore, the PMS staff and the consultant, with the agreement of the ASRS Committee, decided to narrow the range of the ASRS categories of service that would be investigated due to the limited time available for the study.

The ASRS manual describes the statewide alcohol program structure as including three major categories of service: (1)

administrative services, (2) indirect services, and (3) direct services. The indirect and the direct services were identified as the problematic ones, not the administrative services category. Therefore, it was decided to exclude the "Administrative Services" category from the study. See Appendix B for a description of the ASRS program structure and a glossary of terms and acronyms taken from the ASRS manual.

Drinking driver programs were also excluded from examination since they are mandated under separate legislation and were often separate programs.

The site visits were made from June through August 1985. The samples of county alcohol programs and of local service providers are described in Chapter II of this report. A systematic qualitative analysis of the interview materials was made for this final report. The results from this analysis are presented in Chapters II-IV. Recommendations for revising the ASRS based on the study's findings are also presented here (Chapter V).

Chapter II

THE DIVERSITY OF PROGRAMS AND SERVICES VISITED

The study findings are presented in Chapters II through IV. This chapter contains two sections: First, selective characteristics of the county alcohol programs and of the local service providers that were visited are described. Of special interest is whether or not a diverse set of programs on both the county and local levels were included in the final samples. Second, the question "What is the diversity of models of service and the actual services found in publicly funded programs in California?" is answered.

A. COUNTY ALCOHOL PROGRAMS AND LOCAL PROVIDERS VISITED

Fifteen counties were studied, of which 13 were visited. In the remaining two counties telephone interviews with the CAPA's were conducted due to lack of time for visits. The selection of the 15 counties from the list of 24 was done on the basis of recommendations of the DADP staff, the ASRS Committee and partly on the basis of logistics and the availability of CAPA's. Therefore, the final 15 counties included were not all specifically chosen in relation to the criteria of diversity.

A range of counties of small, medium and large population size was visited:

Population Size	Number
Large (1,000,000+)	4
Medium (>200,000 and <1,000,000)	6
Small (200,000 and less)*	5
	15

* One was under 125,000

Small was defined as 200,000 or less population because it corresponds to the membership of the small counties meeting for combined alcohol and drug administrators.

Two other criteria of diversity (type of county administration and type of service providers) for selecting county alcohol programs were met in the 15 counties that were visited. There

were nine alcohol-only CAPA's and six combined administrations. Five of the six combined alcohol and drugs, and one combined alcohol, drugs and mental health. Hereafter the six combined administrations will be discussed as combined alcohol and drugs. In terms of type of service provided, eight counties contracted out their services and seven counties provided most or all of their alcohol services.

The three measures of county diversity appeared to be interrelated. A table was made cross-tabulating size by type of administration and by type of service provider to see if the apparent interrelationships occurred in the data.

Table 1

Type of County Administrator and Provider of Services by Size of County (No.)

	Small*		Medium or Large*	
Type of Administrator	Contract Services	County Operates Services	Contract Services	Mixed; county Operates some/ all services
Alcohol only	0	1	6	2
Combined alc/drug	0	4	2	0
Total	0	5	8	2

*Small is county population size of 200,000 or less. Medium and large are over 200,000.

The type of administration and service provision is related to population size in these counties. All of the five small counties have county-operated services and most of them (4/5) are also combined alcohol and drug administrators. In contrast, the majority (8/10) of medium and large counties contract out their alcohol services; the majority (8/10) are alcohol-only administrators. The most frequent pattern in medium and large counties is the alcohol-only administration that contracts services (6/10).

It would be interesting to determine if the same pattern of relationships among the size, type of administration and provision of services held in all 58 California counties. It is beyond the scope of this study to do such an analysis.

The samples of county programs and of service providers were purposefully developed to insure that several kinds of diversity would be well represented (see Appendix A for details). Therefore, this study did not have a random or representative sample of county alcohol programs or of publicly funded service providers. It is important that the reader does not assume that one can generalize from these findings to all of California's county alcohol programs or to all of the publicly funded service providers.

The sample of local providers of alcohol services that were visited were all publicly funded programs in the 13 counties with two exceptions. Two private-for-profit alcohol programs were visited for contrast with the publicly funded ones and because of interest in the issue of third party payments. The two private-for-profit ones were a hospital program and a nonhospital residential treatment facility. They are excluded from the following discussion of programs unless specifically noted.

The process of choosing which providers to visit in each of the 13 counties was mixed. In small counties (N=5) almost all or all alcohol services funded by the county were visited so there was almost no selection process. In medium and large counties the procedure for choosing providers varied as did the percentage of the programs funded by the county that were visited. In very large counties I visited only a small percentage of their funded programs.

To identify how many programs were visited, the issue of what is a program arises. Programs do not always coincide with a facility (the physical place), a budget category on the ASRS budget form, the organizational entity that administers the program, the program as defined in a legal contract between the county and provider, or the sense of the people involved as to what is a program.

The criteria used in this study were practical ones--(1) What did the CAPA or his/her staff or the provider identify as separate programs? and (2) On what components of service did I observe and collect enough data to constitute a separate program? This definition of what is a program does not correspond well with the ASRS budget categories. For example, in one county with a clinical philosophy there were three major nonresidential centers that had nine budget items for the ASRS (excluding administration and drinking driving programs). Each center had three separate budget items: nonresidential (direct), education and prevention (indirect) and other (indirect). I visited all three centers and spoke to almost all of the staff at each center. The public information, education and referral services were integrated with the nonresidential treatment services at the three centers. One staff member that was interviewed at some length had several special prevention programs at high schools and a jail on which she spent most of her time. For that county I classified that I had visited four programs: the three nonresidential centers and

the one prevention program. The prevention program was separated in this case because I obtained so much information about it and the staff member spent so much of her time on these distinctive youth and jail programs.

By this procedure for counting programs, 66 programs were visited of which two were the previously mentioned private-for-profit programs. Sixty-four publicly funded programs were visited in 13 counties. The procedure used to count programs resulted in the combining of the indirect services (public information, referral, education and prevention) with the direct services in many cases. The procedure for classifying programs therefore seriously undercounts the indirect services that were visited or heard about in interviews. In so many places (clinical, community-social model or hybrids alike), the indirect services are combined with the direct services so that it is difficult to separate them.

The 64 programs were in 58 facilities divided as follows:

2 facilities had 4 separate programs	=	8
1 facility had 3 separate programs	=	3
6 facilities had 2 separate programs	=	12
41 facilities had 1 separate program	=	41
Total		64

The intended diversity by type of service was obtained in the final sample of 64 (Table 2).

Table 2

Number of Different Types of Services Visited

	Number
Hospital	1
Detoxification*	8
Recovery home**	11
Residential treatment	6
Sober living centers	5
Community recovery centers	5
Nonresidential	13
Public info and education	6
Prevention	4
Drop-in	2
Other	3
Total	64

* Four were integrated in the same facility with residential programs

** Includes five homes designed for special populations.

As mentioned above, this classification of programs severely undercounts the indirect services integrated with direct services that were visited.

The plan to visit some special population programs especially for women, Blacks and Hispanics was also achieved (Table 3).

Table 3

Number of
Special Population Programs Visited

	Number
Women	6
Blacks	5
Hispanics	2
Elderly	2
Youth	2
Homeless	2
Public Inebriates	2
Total	21

B. THE DIVERSITY OF MODELS OF SERVICE IN PUBLICLY FUNDED PROGRAMS

During the preparatory phase of the study the issue of whether or not "social model" or "community model" actually existed as an identifiable distinct form and philosophy of service surfaced from a number of DADP staff, ASRS Committee members, and other CAPAs and local service providers. Some people were quite emotional about this issue.

The people who do not believe that there exists a distinct community-social (hereafter "comm-soc") model of alcohol services tend to find arguments for changing the ASRS unconvincing. They tend to believe that the comm-soc model proponents who want changes in the ASRS are trying to slough off accountability to the state. They tend to be professionals with clinical training in mental health, drug abuse, social work, vocational rehabilitation and the like.

Since the major analysis looks at different philosophies of service among the CAPA's and considers what models of service are found among actual programs, it seemed important to confront this issue head on at the beginning of the findings section. Naturally, the concepts, arguments and evidence presented here may not change the opinions of the disbelievers.

The issue of the independent existence of a comm-soc model of service and the associated question of how many alcohol programs actually fit this model is critical to the issue of whether or not to revise the ASRS. If there is no independent comm-soc model of services, then arguments to change the ASRS service categories because it is detrimental to the comm-soc model programs become specious. The controversy surrounding the question of the independent existence of a comm-soc model of services highlights the fact that this issue is partly political. Political is defined here as the differentials in power and its use among persons with opposing interests and values who are competing in the same resource arena (politics does not refer here to Democratic and Republican party behavior).

In August 1985 the first analysis of the data was made to look at the issue of the independence of a comm-soc model of services. I concluded there were at least two distinct philosophies and models of service: community-social and clinical. The two models were described in a paper presented at the August 1985 meeting of the ASRS Committee in Santa Barbara. The paper was revised slightly in January 1986 based on the reactions at the August meeting. A copy of the revised paper is found in Appendix C. Many of the remarks that follow are based on this January paper.

There is extensive terminological confusion in the area of "social model" and "community model." People define "social model" in many different ways. However, in my sociological judgment there is a social movement of proponents who are developing and using the "social model" and the "community model" of alcohol services as a distinct philosophy (see Appendix C). People outside of the social movement vary as to whether or not they are even aware that there is a social movement to promote the development of a "social" and "community" model of service.

A major source of confusion for the unbelievers appears to be the fact that many of them have an early concept of social model that is no longer used by the comm-soc model proponents. This early concept (termed social model definition No. 1 in Appendix C) is what I would call <u>nonmedical</u>. The defining elements of social model$_1$ or nonmedical are: nonhospital setting, no drugs to aid withdrawal, no physicians or psychiatrists, AA meetings are recommended, and peer groups are an element of treatment. This is not a philosophy, just a set of elements that fits within several philosophies. The nonmedical elements fit both the comm-soc models 2 + 3 and the clinical model. By the definition of social model$_1$ almost all but two or three of the 64 publicly funded

programs that were visited are social model[1] or nonmedical. It would be less confusing to use the term "nonmedical" for these cases and reserve the term "social model" for those philosophies that are distinct from clinical programs.

What are the philosophies of models of alcohol services held by CAPA's as preferred policy for their counties? The philosophy of preferred services represents a policy or "wish" that the CAPA is working toward rather than the actual model of services funded by the county.

Philosophies of service model were categorized as: (1) community-social model, (2) clinical, or (3) eclectic. The definitions of community-social model and clinical model follow those in the paper found in Appendix C.

Community-social model is defined as containing the following nine elements:

1. Experiential knowledge of successfully recovering alcoholics is the basis of authority.

2. The primary foundation of recovery is the 12-step mutual aid process (AA or Al-Anon).

3. Recovery is viewed as a lifelong learning process.

4. Staff manage the recovery environment, not individuals; absence of therapist-client roles or accompanying paraphernalia.

5. Participants who embrace recovery become "prosumers", persons who simultaneously give to others and receive services from others.

6. Participants feel they "own" their program and contribute to its upkeep voluntarily.

7. Participants, alumni, volunteers and staff enjoy a relationship analogous to an extended family network.

8. Participants, alumni, and volunteers represent the recovery process and program to the community.

9. The alcohol problem is viewed as occurring at the level of collectivities (such as family and community), not just individuals; activities to change policies, norms and practices of collectivities regarding alcohol use are done.

The community model[3] encompasses the social model (1-8 above) plus the ninth element, the focus on collectivities. For this report, the social and community models described in the paper are combined into the one "community-social model".

The clinical treatment model is defined as the set of elements regarded as important professional practice in alcoholism treatment by graduate school trained and degreed (master's degrees or doctorates) professionals from such human service helping disciplines as clinical psychology, social work, and marriage and family counseling, that also have specific training in alcoholism (see paper in Appendix C, page 5).

Eclectic was defined as a philosophy of allowing a variety of models of alcohol service which could include the clinical, medical, social, community and nonmedical.

The classification of a CAPA's philosophy was made by the consultant on the basis of applying the definitions above to the information available about the CAPA's and their programs. In several cases CAPA's claimed to hold a social model philosophy but their definition of social model fit social model$_1$ or the nonmedical. In such cases they were not classified as holding a social model philosophy as they did not fit the criteria followed here. All 15 CAPA's prefer the nonmedical to the medical model of services.

Table 4

CAPA's Philosophy of Preferred Alcohol Services

Among Those Visited

Philosophy	No.
Community-Social	5
Eclectic	5
Clinical	5
Total	15

Although the initial selection of potential CAPA's included some with each philosophy, it was surprising that there was an exactly equal number in each category (see Table 4) since the definitions of each philosophy was not decided until the analysis.

The relationship between the philosophy of preferred services and the size of the county was examined (see Table 5). There is a strong relationship between the size of county and CAPA's philosophy of preferred service. Small counties that were visited were largely clinical (80%) whereas the comm-soc model philosophies were mostly in medium and large counties (80%). All classified as eclectic were in medium or large counties.

A hypothesis is advanced to explain the predominance of clinical philosophies among small county CAPA's among those visited. These CAPA's have combined alcohol and drug administrations and they often report to Directors of Mental Health. Both drug programs and mental health are very clinically oriented in their reporting systems and in other ways. Thus, the bureaucratic environment in which some small county CAPA's operate is structured in terms of the clinical model. Perhaps there is selective recruitment of CAPA's with the clinical philosophy in these counties or CAPA's find that they are drawn toward embracing clinical philosophy since it permeates their bureaucratic context.

Table 5

CAPA's Philosophy of Preferred Services

by Size of County

Philosophy	Small*	Medium or Large*
Comm-soc	1	4
Eclectic	0	5
Clinical	4	1
Total	5	10

*Small is county population size of 200,000 or less. Medium and large is over 200,000.

How many pure social model or pure clinical programs are there in the field? When is a program similar enough to the model that it can be classified as fitting the model? A model by definition is an ideal framework with a set of defining

characteristics. One does not expect actual programs to correspond 100% with a model. Further, if there are 2-3 elements in a program that are different from a complex model it is still likely to be regarded by many analysts as fitting the model. But at what point is a program too discrepant that it is regarded as not fitting the model? These are difficult questions to answer analytically or pragmatically. There is no accepted procedure for making these kinds of decisions. Usually decisions of this type are made arbitrarily or politically.

For purposes of this report, if a few elements of an operational program diverge from a model of service but the structure of program relationships mainly fit the model, then I would classify the program in terms of that model. Hybrid is a term that is being introduced for cases that seem to have such a mix of elements of two models (including the structure of program relationships) that it departs significantly from a specific model. By this definition there are hybrid-clinical programs which began as clinical or emulate the clinical model, and there are hybrid-comm-soc models that began as comm-soc or emulate the comm-soc model.

In this report the 64 programs will not be classified as to which model they fit. Insufficient information was obtained about many programs to make such a classification. Moreover, it does not seem to be a productive exercise to classify programs by their model in terms of the issues about the ASRS revision. There were clear-cut instances of social model$_2$ programs, many nonresidential clinical programs, hybrid-clinical programs, hybrid-comm-soc model programs, and some cases of programs working toward comm-soc model$_3$.

Among the 64 programs were many programs that were changing rapidly. I found instances of clinically oriented programs that were deliberately restructuring themselves as community-social model programs. They were likely to be nonresidential programs that had been outpatient counseling centers. There were several instances of social model$_2$ recovery homes that had become hybrid-social models with significant elements of the clinical model. Staff controlled residents by making and enforcing important rules, setting program activities, relating to residents as quasi-counselors with case files, monitoring residents as cases in staff review meetings, conducting individual sessions and writing progress notes. A hypothesis is advanced that social model recovery homes that evolve toward hybrids are more likely to be large (30 or 40+ beds) than small. The large homes are less likely to have an internal social-model governance structure. Instead they use formal rules to control residents (signs displaying rules, written handbook of rules that become non-negotiable, etc.). Among other things, I found three large recovery homes that fit this situation. However, there was one exception--a large social model recovery home in a rural area.

For ASRS purposes, it is clear that there is alot of variety in the models of service within many ASRS categories such as "residential treatment". It does not seem fruitful to try to definitely identify what model each program fits. A major reason is that there are many forces for change and any classification of programs into their model type is likely to become obsolete very quickly. Some changes in programs are planned by CAPA's, others are not. Several comm-soc model CAPA's are instituting policies or providing incentives for programs to adopt more community model3 orientations among their programs.

A final question about the diversity of actual services is: What is the correspondence between the philosophy of the CAPA and the programs they fund? Are funded programs similar in orientation to the philosophy of the CAPA or not? For example, do clinically oriented CAPA's fund primarily programs with a clinical focus or not? Etc.

Overall, there seemed to be some but not perfect correspondence between the philosophy of the CAPA and the orientation of the programs they funded. Not surprisingly, the highest correspondence was found with CAPA's with an eclectic philosophy in that the full array of models of service were found among their funded providers. Community-social model CAPA's seemed to have many comm-social model and hybrid comm-social model programs, but they all had some hybrid-clinical model programs as well (or even a few clinical model programs). All but two counties seemed to have a variety of actual models of service that they funded (comm-social model, clinical and hybrids). The two exceptions were counties with a clinical or eclectic philosophy in which only clinical model preograms were found. Please note that one cannot safely generalize from these 13 counties to all of California's CAP's.

Chapter III

THE CAPA'S USE AND EVALUATION OF THE ASRS COMPONENTS

In Chapter III six issues regarding the CAPA's use and evaluation of components of the ASRS are discussed. These findings are based on the analysis of interviews and site visit materials. The six issues covered in this chapter are:

A. The CAPA's Overall Use of the ASRS
B. Problems with the Direct and Indirect Categories
C. Problems with "Participant" and "Visit"
D. Services that do not Fit the ASRS Subcategories
E. Special Accomplishments are Inadequately Noted
F. Problems with Budget Forms and the Cost Guidelines

A. THE CAPA'S OVERALL USE OF THE ASRS

A number of questions were asked regarding the CAPA's use and evaluation of the ASRS and its components. This section includes findings from the interviews with the CAPA's and their staff as well as analyses of some claims that the ASRS categories and definitions do not fit the comm-soc model of services.

The CAPA's and their staff were asked what they thought about the major ASRS categories of service: direct and indirect, how they used and evaluated them. See Appendix B for definitions of these terms.

Many CAPA's had definite clearcut opinions about the direct and indirect categories of the ASRS. The few who hesitated were usually CAPA's who did not use the categories in their day-to-day operations. The answers could be easily classified as negative, positive (o.k.), or neutral (do not care). Half of the CAPAs were negative toward the direct and indirect distinctions, 3/14 were neutral, 4/14 were positive. There was one "no answer."

Some people think that the comm-soc model proponents are the primary ones that are negative toward the ASRS direct and indirect categories, as some of them have been publicly vocal about the ASRS's shortcomings and the mismatch with their philosophy. To identify if the comm-soc CAPA's were the only negative ones, the CAPAs' attitude toward the ASRS categories was cross-tabulated with the CAPAs' philosophy.

Table 6

CAPAs' Attitude Toward ASRS Direct and Indirect Categories by CAPAs' Philosophy (No.)

	Attitude Toward ASRS Categories			
Philosophy	Negative	Neutral	Positive	N/A
Comm-social	5			
Eclectic	2		3	
Clinical	0	3	1	1
Total	7	3	4	1

As expected, the comm-soc philosophy CAPA's were all negative. But 40% (2/5) of the Eclectic CAPA's were also negative. Only 29% (4/14) of CAPA's were positive toward the direct and indirect categories in this sample.

The neutral position of three clinically oriented CAPA's is likely related to the fact that they are small counties with combined alcohol and drug administration. They are unlikely to use the ASRS on an operational basis. Counties with combined administrations face a dilemma in using the state required reporting systems. The reporting systems all differ in their terminology and requirements for data. The reporting systems for drugs (in combined alcohol/drugs) or mental health (alcohol, drugs and mental health) are more stringent and demanding than alcohol. Do you ask a small staff to learn and use two different sets of terminology, forms and procedures in their daily work? If you choose one system, then the staff's terminology, procedures and forms are likely to reflect the orientation of that reporting system. Choosing one system for daily use seems to be a humane and rational solution to the dilemma. If you choose one, you have to choose the most stringent and demanding in order to collect the appropriate data in enough detail. You can always collapse categories for the less stringent system with fewer categories (like the ASRS in comparison with the drug or the mental health reporting systems). The combined administration CAPA's that I visited chose the most stringent of the two (or three) reporting systems for daily use in their programs.

None of the three clinical counties that were classified neutral toward the ASRS categories even used the ASRS routinely. They used the more stringent drug or mental health reporting systems.

The drug and mental health reporting systems are clinically oriented. Reporting systems can act as a significant source of pressure to conceptualize and view the world in its terms when they are used daily to record staff's work, their work with

clients and for accounting purposes. Recognition of the power of reporting systems to shape and constrain one's ideas is one reason the comm-soc model CAPA's are concerned about the mismatch of ASRS with their philosophy.

As previously mentioned, the small county combined alcohol and drug administrators who do not use the ASRS routinely are, not surprisingly, neutral about the ASRS categories and definitions. How do medium and large county alcohol programs use the ASRS and what is its significance to them? Unfortunately, the question of the significance of the ASRS categories was not routinely asked of all CAPA's but many of them volunteered answers to these questions.

Alcohol-only administrators have no choice of reporting systems for their daily operational use as have the combined alcohol and drug administrators. Alcohol-only administrators have to use the ASRS both for their formal county alcohol budgets (CAB) and their county alcohol plans (CAP) and their daily administration of programs with local service providers.

The significance of the CAB and CAP varies from county to county. The political context of the Board of Supervisors, AAB and the bureaucracy within which the county alcohol program works seem to be key factors that affect how significant are the CAB and CAP and therefore the ASRS categories.

Some small combined alcohol and drug administrators described their political context as one in which they know the BOS and AAB members personally, interacting with them socially and on civic projects throughout the year. The CAB and CAP may not be formally used by or significant to the BOS. The negotiations of kinds of services, accountability, budgets, etc. may be done informally without the written CAB or CAP. Thus, the use of the ASRS is minimal for local political and bureaucratic reasons just as it was for daily operations. The ASRS becomes important to these CAPA's only in their relationship to the State DADP.

In contrast, medium and large alcohol-only administrators may find the ASRS to be significant to them not only as it shapes their daily operations but also politically and bureaucratically with their BOS, AAB and the bureaucracy within which they work. Several medium and large county administrators found the categories and definitions of ASRS critical to them. The CAB and CAP were their major political vehicles for negotiating with their BOS and their bureaucracy. These CAPA's also used the county alcohol plan as a major educational tool to inform their AAB, BOS and other constituencies about their philosophy and kinds of services they were developing in their county. Large county CAPA's are often very distant from their BOS and access to county decision making. Many layers of bureaucracy lie between them and the BOS. Some relate primarily to the aides of the BOS. They do not share informal social events or civic projects with their BOS to become acquainted and present their case about alcohol services and

budgets. Therefore, these medium and large county alcohol programs find the ASRS to be very significant to them in terms of their political and bureaucratic negotiations over scarce resources in the county with their BOS and their bureaucratic superiors.

Most comm-soc philosophy CAPA's are alcohol-only administrators in medium and large counties. Therefore, part of the reason why the ASRS revision is important to them can be explained by the political, bureaucratic and operational context in which they work. The ASRS as presently constituted impacts heavily on their work just as it does for other alcohol only administrators in medium and large counties.

The open ended interviews of CAPA's and their staff elicited many spontaneous comments about various aspects of the ASRS. Half of the CAPA's (7/14) brought up concerns about the need for accountability to their AAB, Board of Supervisors and the State DADP, if the ASRS categories were changed. Those concerned about insuring that accountability data were available were four comm-soc model counties, two eclectic counties and one clinically oriented county.

B. PROBLEMS WITH THE DIRECT AND INDIRECT CATEGORIES

Several problems were found with the direct and indirect categories. First, many providers or CAP staff interpreted the direct and indirect categories very differently (as well as the subcategories). Few people seemed aware of the big differences in meaning and interpretation of the direct and indirect categories made by many people. Even people in the same program used the terms differently, classifying the same activity into different service categories.

A second issue is the claim of comm-soc CAPA's that the ASRS categories of service and definitions are implicitly medical (or clinical) and that these medical biases are detrimental to the development of comm-soc programs. An analysis was made of this issue. The arguments were examined and a separate analysis was made independently of the opinions of the comm-soc model CAPA's.

The first question is whether or not the indirect and direct categories of service are implicitly medical or clinical. According to the ASRS manual (see Appendix B Glossary), Direct services are defined as nonresidential and residential services designed to assist individuals suffering from alcohol problems to establish and maintain a recovery program. These services for individual clients are often regarded as the intensive treatment activities that are usually conducted within an alcohol service facility. These residential or nonresidential treatment or recovery services often imply that the recipient and provider of service establish a regular involved relationship, not a one-shot or casual contact.

Indirect services according to the ASRS manual (See Appendix B Glossary) are defined as "community type activities commonly referred to as 'identification and prevention.' " These usually refer to a recipient of services being a group of people in the community who are not "clients." They refer to nonintense information, education and referral activities such as talks to a civic group,class sessions in schools about alcohol problems, public information services and the like. Indirect services are formally defined as community type activities which are often interpreted to mean that they are outside an alcohol service facility. It implies casual contacts, one-shot presentations, nonintense and uninvolved relationships between providers and recipients of service.

Since there were so many meanings and interpretations of the direct and indirect categories (and subcategories of service), I analyzed what were the major common variables or aspects of these terms people seemed to use. Four aspects of these terms seemed to predominate in the implicit or explicit use of these categories: 1. Who receives services?; 2. What is the intensity of service received?; 3. What type of relationship is there between the provider and recipient?; and 4. Where are the services given?

These four variables are listed in Chart I. The traditional medical or clinical meanings of each variable for the direct and the indirect services were put into the chart.

Chart I

Four Variables Combined in the Direct and Indirect Categories

Variable	Direct Services	Indirect Services
Who receives services?	Individual as "Client"	Number/group of community people, not "clients"
Intensity of services?	Intense--treatment/recovery	Nonintense--information, education, referral
Type relationship between provider/recipient?	Regular involvement over some period of time	Uninvolved, one shot event, casual contact
Where are services given?	Inside alcohol service facility	Outside of alcohol service facility

The four variables are bundled together into only two possibilities: direct and indirect services. Many other configurations of these four variables can and do exist but the rigidity of the direct and indirect categories precludes the identification of these other instances. This situation seems to be especially designed for a clear-cut medical model such as a hospital situation. People enter a hospital becoming a patient inside the facility. They receive intense treatment and have a regular involvement with their physician, nurses and other staff over some period of time after which they are discharged. Many aspects of the clinical programs fit also the direct service category but many situations were encountered in clinical programs during the site visits that did not fit neatly into the model of direct services.

The medical model or clinical model does not have the community as a "client." Thus, its activities with groups of people in the community are a different order of activity for them. Community based activities are indirect for them since there is no individual client receiving intense treatment within a facility.

On the basis of this analysis I concur with the comm-soc model CAPA's who argue that the direct and indirect categories are implicitly medical and clinical in orientation. Although they fit conventional clinical practice inside a facility, there are more and more situations where clinical practice is expanding outside alcohol facilities. Accordingly, the direct and indirect categories no longer fit many clinical model situations.

Who are the important recipients of service or the equivalent of "clients" in the comm-soc model of services? Briefly, the comm-soc model posits that alcohol problems are not comprised solely of individuals (problem drinkers or alcoholics) or even their families (co-alcoholics, children of alcoholics), but they also include the larger communities (neighborhood, city, etc.) and society. Communities have social problems with alcohol since they encourage and condone heavy and irresponsible drinking, policies and regulations that facilitate alcohol use, media coverage that glamourizes alcohol use, and the like. When the community is seen to have alcohol problems, then the services and solutions have to expand beyond the individual level to the community level. The community becomes the recipient of services or the equivalent of the "client" along with individuals suffering from alcohol problems. Further application of the ideas of the comm-soc model of services is found in Appendix D, a portion of the Alameda County Alcohol Plan.

How well does the comm-soc model philosophy fit the direct and indirect categories as described above? The categories imply that an individual is the only recipient of "treatment/recovery" services, but this clearly is at odds with the comm-soc model that maintains the individual, the family, and the community all need to be recipients of "treatment/recovery" services since they all are suffering from alcohol problems. In the comm-soc model, the community is regarded just as much the equivalent of a "client" as is an individual. A further detailed discussion of how the direct and indirect categories do not match the comm-soc philosophy of services is found in Appendix D, which excerpts a discussion from the Alameda County Alcohol Plan. I concur with its analysis of how the direct and indirect categories do not fit the comm-soc model philosophy.

C. PROBLEMS WITH "PARTICIPANT" AND "VISITS"

Participant, participant visit, and visit were other ASRS categories of recipients of service that were mentioned in the interviews as troublesome. In nonresidential services the individual seeking recovery/treatment services is categorized either as a participant visit or a visit (see Appendix B, Glossary). These are the only two possibilities. A participant visit is someone who has gone through an intake process with a file established, fee determined and a plan for recovery developed. If he or she hasn't met those four criteria, the only other possibility is to be a visit "when the individual physically enters a nonresidential facility for the benefit of the supporting nondrinking environment."

The definition of participant and the limited possibilities of visit were disliked and problematic to a number of CAPA's and to local program staff. Persons with all philosophies--clinical, eclectic and community-social model--found these terms restrictive and limiting. However, the reasons why they found them problematic varied by the orientation of the person.

For example, a clinical program that had quasi-medical elements found the terms problematic. They had in fact two kinds of clients who received treatment for their alcohol problems: (a) a client with alcohol problems who went through a two-hour intake process to establish a file, determine a fee and develop a treatment plan. The client also received a physical examination at a later point. (b) a client, usually a family member or significant other of (a) above on whom a simple abbreviated intake was done. This client was seen regularly in one-hour sessions of group therapy over a period of months in the center. Client (a) fit the participant category but client (b) did not. However, the "visit" category did not capture the relationship of client (b) with the program. The center developed a category "nonparticipant" to note client (b) and to distinguish them from casual one shot "visits." It became very humorous to talk about the number of client (b)'s who were regular "nonparticipants" participating in group therapy over the months.

Another kind of problem with participant is the fuzzy and ambiguous process by which individuals relate to a treatment/recovery program. Often people with alcohol problems have serious denial that they have any problem. The denial is manifested in their unwillingness to formally relate to a program. They resist going through an intake process to become participants although they may be willing to come now and again as visits. The director of a nonresidential clinically oriented program criticized the participant and visit definitions. On which visit (first, third, fourth) does a visit become a participant? In his center he found that in fact when there were political pressures from the county to generate a large number of participants, then people would be put through the intake process on their first or second visit. Otherwise, the staff would follow a more natural timetable in terms of the attitude of the potential client. But if this intake process is hurried for certain people, they may resist and withdraw. Thus, the reporting requirement affects the therapeutic relationship between the client and program staff.

In the comm-soc model programs, the problems with the definitions of participant are different from those found in clinical programs. An intake process is a clinical concept involving the screening and admitting of a client into a program. People do not enter comm-soc nonresidential programs in that way; an intake process is regarded as antithetical to the spirit of the place. Ideally, entrance is voluntary for the person who may need or take varying amounts of time to get involved in the program. If comm-soc model community centers are viewed as places where extended family-like networks of recovering people develop, then

it is easier to understand why an intake process violates the spirit of becoming involved with a family.

The concept of a file that is required for the participant is problematic when it is interpreted as a case file for individual "clients" with a "counselor" monitoring the client and recording progress notes in comm-soc model programs. That situation fits the clinical case. But the key therapeutic relationship in the comm-soc model is not the counselor-client one as it is in the clinical case. The central recovery relationship is the individual to his/her recovering peers at different stages of sobriety. Thus, on all four criteria the definition of participant does not fit nonresidential recovery programs with the comm-soc model philosophy.

Visits were also a problem term for all types of programs-clinical, hybrid and community-social model. The "visit" limits individuals who partake of services to those who "physically enter a nonresidential facility." Clinical, hybrid and comm-soc model programs have activities sponsored by nonresidential facilities that are held outside the facility. If an event is held within the facility, then the people attending can be counted as visits and the program receives credit for those visits. However, if the same event is held outside the facility, it is often interpreted as not fitting the category. It is then often categorized under Indirect: information, education or prevention activities. There is no provision in the ASRS for counting the individuals who attend events classified as indirect services. The program then receives no credit for the "visits" to outside events.

D. SERVICES THAT DO NOT FIT ASRS SUBCATEGORIES

Another issue raised was the question of various kinds of alcohol services that do not fit the present ASRS service categories. The majority of CAPA's (71% or 10/14) pointed out various services in their counties that did not fit the ASRS categories. Of the four that did not mention ill-fitting services, two were from CAPA's who did not use the ASRS categories in their routine operations. As can be seen in Table 7, CAPA's holding each of the three philosophies of service identified services that do not fit the ASRS categories. Eighty percent of eclectic CAPA's mentioned ill-fitting services as did 80% of the comm-soc CAPA's.

Table 7

CAPA's Mention Services That Do Not Fit ASRS Categories by CAPA's Philosophy

Philosophy	Mention Ill-fitting Services	No Mention of Ill-fitting Services
Community/Social	4	1
Eclectic	4	1
Clinical	2	2*
Total	10	4

* CAPA's that do not use the ASRS routinely.

Being positive about the basic direct and indirect service categories (refer back to Table 6) does not mean wholesale acceptance of the ASRS categories and their usefulness. Three of the four eclectic CAPA's classified positive in their attitudes toward the categories mentioned services that did not fit with the ASRS categories.

CAPA's and their staff identified a number of newer services that have been recently developed that do not fit the existing ASRS categories. They also indicated into which ASRS categories they were placing the newer services. Many CAPA's talked openly about having to "play games" to force services into categories that they did not fit. They acknowledged that there were many invalid (i.e., mixing oranges and cauliflower) classifications of services into categories forced by the limitations of the ASRS categories. The experience of "playing games" to force services into illfitting categories was expressed by CAPA's of all three philosophies; it was not at all limited to the comm-soc model CAPA's.

A majority of CAPA's (of all three philosophies) pointed out newer services that did not fit ASRS categories. Many of these newer services were not being offered in just one county but were found in several of them. A chart was made to show how several of the newer services that have been developed in two or more counties are being categorized currently into ASRS categories. This chart is for illustrative purposes only. It is not an accurate count of all the counties that have each service.

Chart 2

How Selected Newer Services are Classified into the ASRS Service Categories in Various Counties*

ASRS Service Categories	Newer Services			
	Sober living centers	Intervention	Young Children of alcoholics	Jail Diversion
Direct Services				
1. Nonresidential		*	*	*
2. Residential				
a. Detoxification				
b. Residential treatment	*			
c. Recovery home	*		*	
Indirect Services				
1. Prevention				
a. Education		*	*	
b. Regulatory				
2. Identification				
a. Information/referral				
b. Information/education	**			**
Outside ASRS-no state funding	*			

* Each asterisk refers to a specific county.

Reading down each column, one sees that each of the four newer services has been categorized into at least two ASRS service categories. In all cases they are categorized under one direct and one indirect category. There are several implications of this variation in classifying a service into two plus categories.

1. Invalid categories. Some categories contain invalid cases. For example, the "recovery homes" category count of bed days includes persons in sober living centers and children living with their mothers in recovery homes.

2. Incorrect (undercounts) numbers of participants and visits. Since only direct services get counted (as either bed days, participants or visits) whereby programs then get credit for people served, the newer services that are "incorrectly" classified under indirect services will have incorrect undercounts of persons who receive services. And programs will not receive full credit for their activities. Moreover, the counts of the number of persons in recovery programs will be inaccurate because of the invalid cases counted as bed days.

3. Identification of programs offering specific newer services is difficult. Since there is no appropriate ASRS category/subcategory of service for these programs, and they are currently being classified into different categories, it would be difficult to identify how many programs were offering a specific new service. One would have to examine the narratives of the county alcohol plans to identify new services, a long and time-consuming process.

Many other newer services were being developed that did not fit comfortably into the ASRS categories. Three of these and the problems with classifying them into categories will be mentioned:

1. Interfaces with the criminal justice system (excluding drinking driver programs).

A number of alcohol services are being developed and provided by local programs that interface in one way or another with the criminal justice system. One example is court referrals to programs. Several counties conduct relatively elaborate and time-consuming screening sessions for court cases to determine the kind and nature of the individual's alcohol problems and to recommend appropriate kinds of treatment or dispensation. Referring back to the variables found in the direct and indirect definitions in Chart I, these can be one-shot sessions, inside or outside the alcohol facility, but they are intense, time-consuming and use trained staff's time. Are these indirect services because they are one-shot or are these direct services because they are intense? Should they be classified as indirect if they are conducted outside the facility and direct if they are conducted inside the facility? In fact, various programs classify the same activity into direct and indirect categories.

A second example are alcohol services in jails (some alcohol diversion programs fit into this category). Regular group educational and therapy sessions over a period of weeks are held in jails for self or court identified persons with alcohol problems. The individual participates regularly and is involved in a program

of recovery. Some programs or counties classify these as nonresidential services since they include an involved relationship between the alcohol service staff person and jailee, are "intense treatment" and the jailee is a "client" even though the sessions are held outside the alcohol service facility. Other staff, programs or counties count the same type of sessions as indirect services (information/education) because the sessions are done outside the facility.

Also, some programs offer jail programs that are one-shot educational information sessions. These are usually classified as indirect/information-education but they are quite different from the sessions described above.

2. Drop-in centers

There are drop-in centers not just for public inebriates as implied in the ASRS manual definition, but also for the elderly and for youth. Also, some newer sobering up places (with showers, beds, and clean clothes) for public inebriates are for six to eight hours, not for the four hours listed in the ASRS manual.

A significant number of comm-soc model programs that assist individuals with alcohol problems into recovery (they may be called community recovery centers or neighborhood recovery centers) are classified as drop-in centers (or other indirect service categories) for ASRS purposes. The programs fit the "nonresidential direct service" definition of assisting individuals with alcohol problems into recovery. However, the other requirements of the nonresidential category, such as having "participants" who go through an intake process, etc., violate the comm-soc model philosophy as has been described. Therefore, to maintain the integrity of the comm-soc model program, they are classified by their county under indirect services.

3. Relapse services

A number of kinds of relapse prevention services are being developed either within recovery homes or nonresidential programs as "direct" services or as educational sessions classified as "indirect" services. It appears that an increased number of these services will be appearing in the future.

The number of these newer services that are being developed and how frequently they occur does not seem to be the critical issue here. Instead, the fact that many newer services are and will continue to be developed that do not fit the ASRS categories of services is important. It appears that there will be continuous innovations in service among counties around the state. The ASRS needs to be revised to accommodate them.

E. SPECIAL ACCOMPLISHMENTS ARE NOT REPORTED IN THE CAP

Several CAPA's criticized the ASRS and the county alcohol plan in general for restricting the kinds of special accomplishments and achievements that can be reported. County Alcohol Programs are doing a number of special projects for which there is no vehicle to report or receive appropriate credit for it. They felt that they were not getting credit for all their activities, especially their most innovative or distinctive ones. Two major kinds of projects were mentioned several times:

1. Entrepreneurial Start-up of New Services

Many county alcohol programs see their role as being the entrepreneurs to fund start-up costs and initiate pilot tests of a new service in their county. Sober living centers and Employee Assistance Programs (EAPs) were often mentioned as examples that are currently being tried. Some counties funded an EAP or other new service for several years until it had demonstrated its effectiveness. When it was a proven service, the county program turned over the service to other agencies. These special accomplishments are not specifically recorded in the County Alcohol Plan and some CAPA's think that their county does not receive credit for such projects.

2. Distinctive Projects

Several distinctive projects such as policy prevention projects that are breaking new ground were mentioned. Again, there is no appropriate vehicle for recording these special accomplishments on the ASRS or in the county alcohol plan. Many of these projects would be recorded under the indirect service category but there is no recording of achievements from these projects. Some of these projects could be recorded under "administrative services" as the CAPA's are major contributors to them.

This issue is importantly related to the new state-wide Prevention initiative. The state-wide Prevention initiative calls for innovative thinking, community work and pilot tests of distinctive approaches to mobilizing the community for policy prevention projects. If the major accountability system, the ASRS and CAP do not explicitly provide reporting opportunities and credit for these special innovations, then counties might be subtly deterred from risking such innovations as policy prevention projects.

F. PROBLEMS WITH BUDGET FORMS AND COST GUIDELINES

1. COST GUIDELINES

A number of CAPA's and their staff brought up various issues about the cost guidelines for residential services. Costs-per-bed-day are calculated on the budget form only for residiential services following the cost guidelines (see Appendix B, Glossary). The cost guidelines for recovery homes are the lowest of the three residential services.

The most frequent concern was the low salary scales for the staff of detoxification centers and recovery homes. Some expressed concern for low salary scales and lack of basic benefits for comm-soc programs in general. Many programs offer staff no basic benefits such as health insurance. Grave concern about the very low salaries and benefits were vividly expressed by CAPA's in such terms as: "the low pay structure is subsidized through the generosity of staff," "the low salaries of staff in recovery homes are a disgrace," or "we have created a cycle of poverty among caregivers in the system."

The low salary and lack of benefits lead to high turnover in programs according to a number of CAPA's, their staff and some program directors. Staff would work in a program for a period of time, in effect being trained on the job. Then they would leave for higher paying jobs in private-for-profit programs. Although these observations were mentioned a number of times, there was no data available to identify how often this happened or how serious a problem it was.

Another concern was that cost guidelines were too low. They had not been updated to keep pace with changing expenses. For example, liability insurance was increasing much faster than the cost-of-living index. Several CAP's located in urban counties with high priced real estate were hindered in the development of new residential facilities because of the cost guidelines. Also, there was no financial help with the start-up costs of new facilities. Consequently, the financial structure retarded the development of new residential facilities.

A number of CAPA's, their staff and program directors suggested that a reexamination of the cost guidelines was in order. Such a reexamination should include a look at the salary and benefit levels. I concur with their suggestions and recommend that a special thorough study of the cost guidelines should be made.

The five CAPA's expressing extensive concern about low salaries and cost guidelines were from medium and large counties where almost all of their services were contracted. The concern was expressed by CAPA's with both the comm-soc philosophy and the eclectic philosophy.

CAPA's in four counties where services were county operated (usually the small ones with clinical orientations) were unlikely to express concern about low salary and benefit levels of staff. In some of these cases the county salary levels seemed to be substantially higher than those paid in counties that contracted services. One example was given by a county with both county operated and contract services. The CAPA said that the director of a contract service received $15,000 a year which is what the CAPA's secretary made on the county pay scale.

2. COUNTY ALCOHOL BUDGET

Some CAPA's as well as the ASRS Committee expressed serious reservations about the current format of the county alcohol budget and how it hindered the development of services. The concerns of the Committee were considered and a short independent analysis of the CAB forms and the Committee's recommendation was made here.

Some/many of the ASRS Committee members think that the bundling together of the indirect and direct service categories and subcategories, the measures of units of service, and costs with the monies planned for each provider complicates an already problematic situation. They recommend unbundling the planned monies from the units of service, costs, and service categories and subcategories. A revised CAB form would require each provider to report monies from different sources. The types of services and measures of units of service and costs would be handled by some other means in order to provide the necessary data for oversight and information to the State DADP and the legisla-
ture.

First, what information is required on the CAB forms? The services of providers are divided into two basic categories--direct and indirect. There are three basically similar forms that vary slightly. The indirect service form has no requirement for measures of unit of service or costs. The two direct service forms require some measure of unit of service (and/or costs). The nonresidential form asks for number of participants, number of participant visits and number of visits for each provider. The residential form asks for number of bed days and cost-per-bed-day.

There is no accountability built into CAB for indirect services that links monies to units of service. The DADP does not know what it is buying with indirect services in comparison with direct services. But this inconsistency does not seem to bother many people.

For the direct services, accountability is obtained by linking monies to measures of units of service. For nonresidential programs the units of service are the number of participants and visits. For residential programs the units of service are number of bed days. But the unit of service measures are not comparable in the nonresidential and residential programs. One cannot add "bed days" to "number of participants" to derive a total figure of the number of people receiving treatment/recovery services. Further, only for residential services is there a concern with cost per unit of service (cost-per-bed-day). Historically, the interest in cost-per-bed-day for residential facilities was to discourage the use of very expensive hospital treatment services. Currently, however, some CAPA's and providers think that the DADP sometimes focuses too narrowly on cost-per-bed day and has lost sight of the original reason for it.

Problems with the direct and indirect service categories and subcategories were identified earlier in Chapter II. The categories are incomplete since there are new services that do not fit in them. People now interpret them differently, classifying the same service into direct and indirect categories, so that they produce invalid data. These categories fit a medical model of service that works somewhat for many clinical programs but not for all. The categories violate the comm-soc model philosophy. Many CAPA's are squeezing in services into ill-fitting categories because of the limited possibilitiles in the ASRS.

Also, the problems with the definitions of participant and visit were discussed earlier. These problems with inadequate categories, inconsistent classification of services into categories, etc. are compounded when the services and units of service are tied to monies. For the State DADP, the problems result in data that have more errors (less valid and reliable). County alcohol programs face the serious consequences of squeezing actual services into ill-fitting categories because they are tied to monies. The rigidity of the current budget forms limit the capacity of the CAPA's to plan services or negotiate within their political context.

It seems that the compounding of problems and serious consequences would be more likely to occur in medium and large counties with alcohol-only administrators in which the CAB and the CAP are major political documents to negotiate with their bureaucracy and BOS. Small counties with combined administrations that use drug or mental health reporting systems operationally, bureaucratically and politically are less likely to be seriously affected by these problems.

CAPA's of all philosophical orientations gave small examples of how they had been constrained by the current budget forms. Community-social model CAPA's were especially constrained by the CAB because they conceptualize services so differently than do the medical or clinical models. In the comm-soc model, prevention-community activities (indirect) are an essential integral part of individual recovery services (direct). The existence of direct and indirect categories artificially separates the individual and community recovery activities. Further, it puts on onerous requirements, especially for small programs, of separate cost centers when the community activities are more than 20 percent of the costs of direct services. In a true comm-social model program, it is artificial and difficult to even separate the individual and the community activities since they are occurring together. See Appendix D for additional rationale on this issue.

A worse-case example of how serious the consequences of bundling together the service categories with monies will be presented. A medium size county BOS was faced with reduced funding. They looked at the CAB forms and where monies were allocated. They decided "indirect prevention and education" was less important than direct services. For one provider they eliminated the indirect portion of the budget, which was a significant percent of the money of a comm-soc model recovery home. The concept of this community recovery home was that extensive interactions would occur among residents, volunteers and the neighborhood and community. Many community information, education and prevention activities could be held for the residents and the community; these activities constitute part of the recovery plan of the individual. The BOS damaged severely the integrity of the program by arbitrarily eliminating a total category of money that it regarded as unimportant. The community model recovery home could not indicate how these "indirect" services were an integral part of their recovery program due to the limitations of the ASRS. If there had been no restricted ASRS categories, the community recovery home could define themselves according to its philosophy and include the community information, education and prevention monies as an integral part of its services. If budget cuts were threatened, the whole recovery home as a unit could be examined for budget reductions rather than the situation which violated its integrity. But, in this case, the BOS saw the indirect monies as tacked on to the recovery home and did not understand how critical they were.

Chapter IV

THE INADEQUACIES OF THE DATA FROM THE ASRS

Two topics are discussed in Chapter IV. First is the issue of the kinds of inadequacies in the data from the ASRS. This issue is especially important because the State DADP, legislature and the public rely on these data for oversight or information. Second, the topic of selected emerging issues that might impact on revisions to the ASRS is mentioned. It was the final topic on which data were collected during the site visits. Unfortunately, there was inadequate time for much analysis of these issues for this report.

A. THE INADEQUACIES OF THE DATA FROM THE ASRS

In the preparatory phase of the study, several DADP staff and an analyst from the Legislative Analyst office were interviewed to identify what data they used from the ASRS and what data were needed for oversight and information by the DADP and the legislature. No discussion of their data needs are given since it is outside the scope of this report. However, two central facts became clear from these interviews. First, various kinds of information about the local programs, their services, activities and participants are used and needed by the DADP, legislature and the public. Second, the DADP staff and others who rely on the data from the ASRS assume it to be reasonably valid, accurate, and reliable.

An analysis was made of how adequate are the current ASRS data and the kinds of inadequacies in it. Much of this analysis of the validity, reliability and completeness of the current ASRS data is mentioned or implicit in Chapters II and III. This section presents an overview of five kinds of inadequacies found in the current ASRS data:

1. Invalid and Unreliable Data in Categories
2. Lack of Categories for Certain Services
3. Errors in Counts of Units of Service
4. Special Achievements and Accomplishments Cannot Be Recorded
5. Inadequate Information on Services for Special Populations

1. INVALID AND UNRELIABLE DATA IN CATEGORIES

Validity and reliability are technical statistical terms that refer to kinds of adequacy or inadequacy of data. Validity refers in part to the problem of whether a given name, definition and sorting procedure belong together. A valid case of data on fruit (name) contains a definition and a sorting procedure (e.g., a list of all the different edible items that could be classified as fruit. It could have apples and oranges in it but not the vegetable cauliflower). Two kinds of reliability are pertinent here: (1) given the same name, definition and sorting procedure will two, three or more sorters in fact put the same items (orange) into the same category (fruit); (2) will the same person or program sort the units into the same categories on successive days or occasions? These kinds of invalid and unreliable data will be discussed:

a. Disparate Services are Classified in the Same Category.

A number of instances of invalid data (which are also unreliable) were identified earlier in Chapters II and III.

In Chart 2 newer services that did not fit the ASRS service categories were put into existing categories (cauliflower was put in the fruit category). For illustration, two other cases of invalid and unreliable data will be briefly described, one residential direct service (recovery homes) and one indirect service (prevention-education).

Recovery homes (direct). In actual practice the following cases were coded in the recovery home category. Note that errors in categorizing also pertain to the number of bed days and costs-per-bed-day.

(1) Recovery homes as defined in the ASRS manual (See Appendix B, Glossary).

(2) Start-up costs for sober living centers.

(3) Recovery homes that have up to 20% of costs for public information, education, and prevention (indirect) because of the comm-soc philosophy. This inflates bed-day cost.

(4) Detoxification services by recovery home staff for incoming residents (since there is no detoxification facility in the vicinity).

(5) Children who live with their alcoholic mother in a recovery home (counted as a bed day).

(6) Missing from this category are new recovery home facilities that fit the ASRS manual definition but were too expensive to fit the cost guidelines so they are categorized as residential treatment facilities.

(7) Who knows what else.

The second example is prevention-education (indirect). The following cases were actually classified in this category:

(1) Community education presentations in the community and schools (as fits the ASRS manual).

(2) Some educational presentations for the community inside alcohol programs but not others because programs code them differently.

(3) Play therapy sessions with young children of alcoholics inside a service facility. Their art work is analyzed by a psychiatrist for evidence of pathology.

(4) Three-day camping trips in wilderness areas for adolescents, school teachers and alcohol staff.

(5) Intervention sessions for families with an alcoholic. The intervention techniques are from the Johnston Institute and require intensive training of staff. The interventions are likely to include 4-6 two-hour sessions of family members and two therapists (and are therefore involved and intensive).

These five activities differ extensively in client's involvement and the intensity of service.

b. The Same Services are Classified into Different Categories.

A second kind of invalidity and unreliability is when the same service is classified into different categories. The most serious problem encountered of this type was with sober living centers. A number of counties are starting up sober living centers. They intend to make them self-supporting or turn them over to other agencies. Earlier in Chapter III (see Chart 2) five cases were shown in which sober living centers were coded into three different ASRS categories.

2. LACK OF CATEGORIES FOR CERTAIN SERVICES

In Chapter III many instances were described of the lack of categories for actual services. Some of these apply to comm/soc model services that combine services in ways distinctive to the ASRS. Others apply to many newer services that are emerging and will continue to develop in the future.

3. ERRORS IN COUNTS OF UNITS OF SERVICE

Two kinds of errors will be briefly mentioned in the counts of units of service. First, there are errors in counts of bed days because of the invalid, unreliable data described in the problem above. Second, there are serious undercounts in the number of persons with alcohol problems who are assisted into treatment/recovery (the question of "How many alcoholics are you treating?).

The undercounts of numbers of "alcoholics receiving treatment" occur because data on participants are obtained for nonresidential direct services only. The residential programs provide number of bed days, not number of participants. In addition, there are several cases where people receiving treatment/recovery services are coded into indirect categories. These include:

(a) Public information, education and referral programs or drop-in centers that are neighborhood/community recovery centers (often comm-soc model) where people receive the equivalent of "treatment" in the nonresidential category.

(b) EAP program participants who are receiving "treatment" services in the community, not just identification and referral. But all EAP services are classified under indirect.

(c) Diversion programs with the criminal justice system that are classified as indirect because they are provided in a jail or outside the alcohol program even when the services are identical to the "treatment" received by participants inside the nonresidential facility.

4. SPECIAL ACCOMPLISHMENTS CANNOT BE RECORDED

There is no means to report special accomplishments and achievements. As described earlier in Chapter III, a number of CAPA's criticized the lack of a vehicle for the county alcohol program to report its special accomplishments and achievements. If the DADP is concerned about accountability in how state funds are spent, the reporting of special achievements sounds important and significant. Qualitative reporting of "success stories" or narrative reports of accomplishments could be encouraged in the narrative section of the county alcohol plan.

5. INADEQUATE INFORMATION ON SERVICES FOR SPECIAL POPULATIONS

The CAB has a code for each provider which allows a primary and secondary code of the population served by that program. This is a crude category as one cannot identify if the program is mixed for several populations or specialized for a given group such as women. In mixed programs coded as general population, one might have significant numerical minorities of special populations served but it cannot be identified from the crude category. Therefore, the number of services for special and underserved populations cannot be adequately obtained.

In addition, for those programs identified as serving primarily special populations, the problems with inadequate data described above all apply here. Therefore, there is a serious lack of adequate information on the number and types of services for special and underserved populations. The available data suffer from the inadequacies of all the other data.

An additional limitation to these data is that there is no indication of whether or not the services for special populations are culturally relevant or adapted to their particular needs.

Given the existence of the inadequaciese of the data from the ASRS, the next question is how serious are they? What are the implications for the ASRS revision? There is no way to pinpoint the extent of these various kinds of data inadequacies in a study like this. From the interviews and my impressions they all seem to be big problems that occur frequently. My impression is that the first three problems are especially numerous. In my opinion the errors are compounded by being bundled with the CAB's. I concur with the ASRS Committee that the present data on service, units of service and costs are extremely inaccurate. An alternative data collection system needs to be devised that provides more valid and reliable data on services, units of service and costs.

B. SELECTED EMERGING ISSUES THAT IMPACT ON THE ASRS

A number of emerging issues were considered in the planning phase of the study that might impact on revisions to the ASRS (see Appendix A). The six selected issues that were covered in some interviews were:

(1) Service needs for underserved and special populations;
(2) Third party payers in publicly funded programs;
(3) Combining alcohol and drugs into substance abuse;
(4) Credentialing of counselors;
(5) Volunteers in publicly funded programs; and
(6) Policy prevention projects in relation to the state-wide initiative.

A seventh issue developed from the interviews and site visits was that an increasing number of involuntary participants are coerced into attending alcohol services by court order. What will be the impact on programs of involuntary participants, especially those programs that assume voluntary participation such as the comm-soc model?

Unfortunately the consultant ran out of time and resources to finish the systematic analysis and write-up of these issues. A few comments and one recommendation will be made about one issue, the planning of services for underserved and special populations.

The county alcohol programs are now required to present their plans for meeting the service needs of special populations in their area in the CAP. Counties vary as to their knowledge of and expertise about the distinctive aspects of alcohol services for various special populations. Some counties could benefit from suggestions about how to plan for the service needs of special populations. The special consultants for women, Hispanics, Blacks, etc. have knowledge and resources for planning for these special population needs. They could be consulted to provide suggestions to the Alcohol Division. Some suggestions on issues to consider in planning for service needs of various special populations could be included in the ASRS manual or provided separately to interested counties.

Chapter V

RECOMMENDATIONS

Six major recommendations are presented here to the Division of Alcohol Programs. A brief rationale for each recommendation is provided; the more detailed results of the study that underpin the recommendations are found in Chapters II-IV.

1. Separate the services, units of service and costs-per-bed-day from the county alcohol budget. Accept the revised county alcohol budget, the simplified budget proposed by the ASRS Committee that presents each provider's costs for "alcohol services" only by sources of funding.

Rationale: Bundling together the program cost data and number of service recipients for each service category or subcategory (a) contributes to unreliable, invalid, error-filled data on costs, service recipients and service categories/subcategories; (b) encourages "game playing" among counties of all philosophies (clinical, eclectic and community-social) because the basic definitions and categories are limited and inadequate; and (c) restricts planning and program development especially in medium and large counties with alcohol-only administrators where the county alcohol budget and plan are major political and bureaucratic tools.

2. Develop an alternative procedure (to the ASRS) for collecting information on estimates of the number of people receiving various services (perhaps a state-wide point prevalence study).

The alternative procedure to collect information on units of service would need to revise the current units of service found in the CAB (participants, visits and bed days).

Rationale: The current units of service (participants, visits and bed days) are too limited and noncomparable. They currently produce invalid, unreliable and error-filled data. Other comparable, less restricted measures of units of service need to be developed for an alternative data collection on estimates of the number of people receiving various services.

The current ASRS data on units of service are inadequate and not comparable across service categories (participants in non-residential and bed days in residential). Also, the categories are too restricted. The alternative procedure to be developed, such as a state-wide point prevalence study, should not be continuously obtrusive on the day-to-day operations of programs. However, it should be designed so that the sources of error can be known and controlled within reasonable bounds. Controlling error sources is impossible when a data collection system is linked together with a planning and budgeting process as in the current

ASRS. The alternative data collection procedure should be designed by statisticians and experts in sampling and survey methodology to be scientifically adequate.

3. Develop a cafeteria list of services or activities to substitute for the current ASRS service categories and subcategories. The cafeteria list would have standardized definitions. It would be inclusive of all activities/services irrespective of the orientation of the program--comm-soc, clinical, eclectic, quasi-medical or other. It would be philosophically neutral.

Eliminate totally the direct and indirect categories to describe services (a subrecommendation).

Rationale: The direct and indirect categories should be eliminated totally from the DADP nomenclature. The categories are logically indefensible since they bundle together four variables into two combinations when in fact many other combinations of the four variables exist now in county services.

Programs and counties differ in their interpretation of the meaning of direct and indirect. As a result, many errors in classifying services into categories are made. In addition, the rigid boundaries between alcohol service facilities and the community that are assumed with the direct and indirect categories have broken down in practice. Direct is interpreted to mean treatment/recovery services within a program and indirect is interpreted to mean community activities outside the program facility. Neither case is true any longer. On one hand, counselors do "treatment" in jails, schools and other community places. On the other hand, programs host community information and education activities inside and outside their facility. These occur with programs of all orientations--clinical, comm-soc model and hybrids.

Section 11811 of the Health and Safety Code, amended (AB-3872) states that "...services shall include, but need not be limited to, both of the following broad categories: (a) Direct services... and (b) Indirect services...." I do not see from this wording that the DADP is required by the legislation to use the direct and indirect terms. The terms seem to be used in a descriptive manner in the Health and Safety Code.

A cafeteria list of services and activities is needed to replace the current ASRS categories and subcategories because they are too limited. A very large number of alcohol services do not fit comfortably within existing ASRS service categories. These services are provided by all models of service--clinical, hybrid, comm-social and quasi-medical. Furthermore, there are a number of newer services that are being developed in many counties that do not fit the existing categories. This situation is likely to worsen in the future. The lack of appropriate service categories means many errors of misclassification of services are made due to the limitations and rigidities of the system. The resulting data on services in the ASRS are invalid, unreliable and inadequate.

4. Develop a procedure for reporting special accomplishments in the narrative section of the county alcohol plan. Encourage county alcohol programs to report their "success stories" of new alcohol services they have developed, distinctive projects or noteworthy accomplishments.

Rationale: The existing data collection systems (ASRS and CAPPS) produce quantitative data on services or units of service. Some CAPA's thought that another vehicle for reporting "success stories", especially those of new programs or distinctive projects, could be a supplement to existing data sources. Many fund-granting entities such as legislatures and BOS find testimonials and "success stories" compelling evidence of well spent funds. These narrative depictions of accomplishments can also be means of education and publicity about programs. Many county alcohol programs are very proud of their achievements but they have no vehicle for publicizing them to their funding agencies or for receiving credit for them.

5. Develop suggestions for planning service needs for special and underserved populations for the CAP. Provide county alcohol programs suggestions for how to plan the distinctive service needs of various special and underserved populations. Obtain ideas and resources from the special consultants on women, Hispanics and Blacks on this recommendation.

Rationale: The county alcohol plans are required to present their plans for meeting the service needs of special populations in the CAP. Some counties lack adequate information about the service needs of the various special and underserved populations. They could benefit from suggestions about how to do this planning for various special populations. The special consultants are a resource with knowledge about the special service needs of their populations. Ideas and resources could be solicited from them. Suggestions for planning service needs could be provided either in the ASRS manual or separately to interested counties.

6. Conduct a special study of the cost guidelines for residential services utilizing trained experts. The Alcohol Division should develop a special in-depth study of the cost guidelines.

Rationale: A large number of issues surrounding the cost guidelines for residential services were raised by CAPA's, their staff and by programs. The issues are serious, complex, and interrelated. The current costs-per-day data are invalid and inadequate. Before an alternative means of collecting costs-per-bed-day data are found, a study of the whole situation is warranted.

The study should consider at least the following:

a) How adequate are staff salaries and basic benefits (e.g., health insurance) in different kinds of residential programs? Do low salaries and lack of benefits lead to staff turnover and loss of trained staff to private-for-profit programs? How serious a problem is this?

b) Evaluate the basis on which cost guidelines were developed. What factors have changed since the guidelines were set (e.g., increase in prices of real estate, utility bills and liability insurance beyond the cost of living increases)? What modifications, if any, need to be made in the cost guidelines?

c) To what extent and how are the current cost guidelines deterring the development of new residential facilities? What means can be developed to increase the development of new facilities?

d) Consider the effects of the following kinds of diversity in counties on the above questions: prices of real estate and liability insurance, county operated versus contracted services, size of county, type of administrator (alcohol-only versus combined alcohol and drugs) philosophy of service (comm-soc, clinical and eclectic), etc.

e) Determine an alternative procedure for collecting more valid and adequate data on costs-per-bed-day than the current CAB form.

Appendix A

STUDY PLAN AND METHODS

The development of the study plan and its method are presented here as occurring in three phases:

I. Preparation of the Study Plan

II. Collecting Information: Site Visits to Counties and to Programs

III. Analysis and Development of Recommendations

In actual fact the three phases were not distinct but overlapped. For example, preliminary recommendations were made to the ASRS Committee before the site visits were all completed and the formal systematic analysis of interview data had been made.

I. PHASE I: PREPARATION OF THE STUDY PLAN

Preparation of the study plan constituted the first phase during June and July 1985. To gain familiarity with the issues and their context, I attended various meetings of County Alcohol Program Administrators Association of California (CAPAAC) and the Alcohol Division staff, interviewed DADP staff and other persons, and reviewed pertinent written materials.

Four topical areas of questions that emerged from the preliminary work as important foci of the study are:

(1) What is the diversity of models of alcohol service and the actual services found in publicly funded programs in California? This issue included the philosophy of preferred model of service of the CAPA's as well as the models of service found in locally funded programs.

(2) How do the County Alcohol Programs use and evaluate the ASRS? The preliminary work showed that local programs seldom knew or used the ASRS categories of service but these issues were important to the County Alcohol Programs.

(3) How adequate are the current data from the ASRS given the oversight and information needs of the State DADP and the legislature? The major data related to the ASRS about alcohol services, participants and programs needed by the DADP and the legislature for oversight and reporting was considered. Other major sources of data about alcohol services and programs were also briefly considered. The kinds and sources of inadequate data from the ASRS were identified.

(4) A number of special issues are present or developing in the future that might impact on the ASRS. Selected issues were examined including the service needs of special and underserved populations, third party payments, combining alcohol and drugs into substance abuse, and the credentialing of counselors. How might these selected issues impact on any revisions to the ASRS?

The study plan involved the use of site visits and interviews to collect qualitative data bearing on these four issues. Site visits would be made to two purposive samples: (1) a sample of county alcohol programs, and (2) a sample of local alcohol service providers funded by the counties that were visited. Answers to question (1) above would be obtained from both the county programs and the local providers. Answers to question (2) would be obtained from interviews of the CAPA's and their staff. Answers to question (3) were obtained partly from interviews and meetings with DADP staff, especially Alcohol Division staff in the preparation phase of the study and analysis of the site visit data. Answers to question (4) would be obtained from the county programs, the local providers and other specialized interviews. Some state-wide consultants representing special populations and volunteers were interviewed.

A. Purposive Sample of County Alcohol Programs

A purposive type of sample was selected rather than a random or representative sample of counties. A purposive sample selects criteria that are practically or theoretically important to the issue under study. In this case diversity among county alcohol programs in selected ways were regarded as important to the CAPA's use and evaluation of the ASRS or its components. Counties were purposefully selected that fit four criteria of diversity that were regarded as important.

Four criteria were used to insure that a diverse set of counties were selected. First, diversity in the philosophy of the model of services that the CAPA preferred was regarded as crucial. The comm-soc model philosophy proponents who claimed that the existing ASRS definitions and categories thwarted them from developing their programs were one important group. Other CAPA's were known to prefer a clinical philosophy of services. They were an important second group. Finally, some CAPA's seemed to have a philosophy that included a variety of models of service without a preference for one; such philosophies were called eclectic. The remaining three criteria were viewed as important factors affecting the politics and context of administration impinging on the use of the ASRS. Second, diversity in size of county (measured as population size) was considered, with concern that small, medium and large counties were included. Third, the type of administrator the CAPA was: alcohol-only, combined alcohol and drugs (or combined alcohol, drugs and mental health). Fourth, counties that contract out all their services versus counties that are direct providers of service.

A tentative list of 24 counties was compiled from the suggestions of the PMS staff of the Alcohol Division. The ASRS Committee reviewed this initial list of counties. Some general priorities were established for what counties should definitely be visited since it was clear there was insufficient time to visit all 24 counties. The consultant made the final selection based on the recommendations of the PMS staff and the ASRS Committee. To some extent final choices were made on the basis of ease of scheduling (the CAPA was available during the time period) and logistics (scheduling adjacent counties during the same period of time to maximize the number of counties visited).

B. Purposive Sample of Local Program Providers

The objectives of the study were explained to CAPA's when site visit arrangements were being made. One objective was to visit and collect information on the diversity of alcohol services actually being funded including the newer services that might not fit well into the ASRS categories of service. Also, there was interest in visiting a variety of types of services now categorized as indirect and direct including: the three types of residential facilities (detoxification, recovery homes and residential treatment), nonresidential direct services, and such indirect services as public information, education and referral and prevention programs. Different program models (i.e., comm-soc model, clinical, quasi-medical, hybrids) were of interest. Finally, some programs for special and underserved populations were considered. These four types of diversity (newer services, a variety of ASRS service categories, different program models, and programs for special populations) were the basis of the purposive sample of local providers.

The CAPA's prepared a list of their funded alcohol services that would be visited by the consultant. They usually discussed a preliminary list with the consultant; often the CAPA and the consultant agreed on the final list together.

C. Confidentiality

To promise and maintain confidentiality of answers by personal name, program name and location were regarded as important to increase the chances of obtaining honest complete answers to these sensitive topics. Since the ASRS affects the funding that programs and counties receive and the account-ability between programs and funding sources, these are very sensitive matters. Interviewees were assured that their names and locations would not be revealed in any study materials. In preparing this report, not only have the confidentiality of counties, alcohol services and persons interviewed been maintained, but other identifying information about a program that would make it easily recognizable has been eliminated.

II. PHASE II: COLLECTING INFORMATION

A preliminary interview guide was developed before the site visits. The guide listed the topics and suggested open-ended questions to ask regarding each topic. It was not a standardized set of questions that one asked of all respondents. The interview guide and the procedures for the visits were tested out during the first few visits. They were modified and refined on the basis of that experience.

Certain questions were only asked of CAPA's and their staff when it was discovered that local programs did not know about the ASRS direct and indirect categories. Other questions about emerging newer services or services for special populations were asked only of those to whom they applied. The questions about the selected special issues were not asked of all persons interviewed but they were asked as seemed appropriate or as time allowed.

The procedure for the site visits was as follows: (1) The consultant visited the CAPA's office for an interview with the CAPA and his/her staff. (2) Interviews with the CAPA privately or in a group with selected staff were held. Interviews with the county staff responsible for developing the county plan and using the ASRS categories were likely to be held. (3) Visits were made to the alcohol service providers that had been selected by the CAPA and his/her staff and the consultant. In the first few visits, the polite and considerate CAPA or his/her staff would drive the consultant to the programs because she was unfamiliar with the area. However, it became quickly apparent that providers seemed inhibited if their CAPA or county staff monitor were listening to their interview. The procedure was changed when this was realized to insure that the local service provider had a private interview without any CAPA's or their staff present.

Each county was visited from 1-4 days. Small counties were often visited for one day (spending the morning with the CAPA and his/her staff and the afternoon visiting programs). In medium or large counties, visits of 2-4 days were usually made. Visits to a facility where one or two programs were housed usually occupied 2-6 hours. A longer visit of six hours usually included visiting two programs in one facility such as a detoxification program in a recovery home. Each interview began with a brief discussion of the reason for my visit and the discussion of confidentiality of their answers. Handwritten notes were taken verbatim and in some detail during the interviews. Other observations of the facility and the site visit were written up by the consultant after the visit. Notes were usually reviewed shortly after the visit for completeness and understandability.

A visit to a program included interviews with the director and staff (individually or in a group as they preferred) and a tour of the facility. Often some event was observed or participated in such as a group meeting, resident council meeting, lunch, staff talking to participants, or the resident council screening a potential resident. I observed two certification and licensing visits from the State DADP staff to a detoxification program and to a recovery home operated by the same provider.

Two private programs were visited in addition to the publicly funded ones for several reasons. For contrast, the for-profit programs were compared with the not-for-profit public programs. Also, with the interest in third party payers as a possible development in publicly funded programs, the private hospital and a nonmedical residential program were visited.

Overall I received a positive open reception both in the county offices and in the local programs. In only two programs were the staff cool and suspicious of my visit. Generally, the interviewees seemed willing to answer all questions in a straightforward, open and honest manner. When I assured them of the confidentiality of their remarks, many people quickly responded that they had nothing to hide. However, it was my impression that the assurance of confidentiality led to more frank, thorough discussions of the sensitive issues.

III. PHASE III: ANALYSIS AND THE DEVELOPMENT OF RECOMMENDATIONS

Although the plan of the study is presented here as if there were three distinct phases, in actuality some analysis was done before all data were collected. Also, some preliminary findings and recommendations were presented to the Alcohol Division staff and to the ASRS Committee before the analysis was completed.

A selected analysis of the information on counties and on local programs was made in August 1985 on the issue of whether or not there were significantly different models of alcohol services. A paper based on this analysis was written that argued that there were at least two different models of services. Preliminary recommendations for changing the ASRS were developed in August 1985 also. The two models of services and the recommendations were presented to the ASRS Committee and to the Alcohol Division staff at a meeting in August in Santa Barbara. A January 1986 ASRS Committee meeting discussed these recommendations for modifying the ASRS. In January 1986 the above-mentioned paper was also revised based partly on the input from the Alcohol Division staff and the ASRS Committee members (see Appendix C).

A systematic qualitative analysis of the interviews, site visit observations and associated written materials was conducted for this final report. Written notes from interviews and observations were coded by topic. Answers to the same questions could then be compiled for all CAPA's and their staff or for local programs who had responded to them. The interest was in a qualitative analysis that maintained the flavor and complexity of the original answers (which had usually been recorded verbatim or near verbatim). For some questions, a systematic compilation of the answers were coded for all CAPA's. The simple code categories were derived empirically from the array of interview answers available. In these cases simple frequency distributions or cross-tabulations of two factors could be presented in a table.

The substance of most of the final recommendations is the same as the preliminary recommendations. Some of them were rewritten to more accurately convey the sense of and rationale for the recommendation. The rationales and evidence in support of the recommendations are also found in this report. Some of the recommendations coincide with those of the ASRS Committee. This is not unexpected in that I was aware of the work and recommendations of the ASRS Committee. However, I independently arrived at the recommendations presented in this report.

Appendix B

GLOSSARY AND ASRS PROGRAM STRUCTURE AND DEFINITIONS

Appendix B contains a glossary of terms and acronyms that have been taken from the ASRS manual unless otherwise noted. The ASRS structure of categories and definitions taken from the ASRS manual are also included following the acronyms.

1. GLOSSARY

ADMINISTRATIVE SERVICES. County management functions including county program management, planning, monitoring, controlling, training, evaluation and quality assurance, provided to improve the efficiency and effectiveness of county program services.

ADMISSION. The acceptance of a person into a provider's program for the first time, or the reacceptance of the person after discharge from the provider's program.

ADVISORY BOARD ON ALCOHOL PROBLEMS (ABAP or AAB). An appointed body of designated community representatives who participate in the planning process and advise the county alcohol program administrator and the Board of Supervisors on policies and goals of the county alcohol program.

ALCOHOL PROBLEMS. Problems of individuals, families, and the community related to inappropriate alcohol use and including conditions usually associated with the terms "alcoholism" and "alcohol abuse."

ALCOHOL PROGRAM. A collection of alcohol services which are coordinated to achieve specified objectives.

ALCOHOL SERVICE. Any service that is specifically and uniquely designed to encourage recovery from problem drinking and to alleviate or preclude alcohol problems in the individual, his or her family, and the community.

COMPONENT. A constituent part of a larger whole; for program budget purposes, components are parts of elements. Elements, in turn, are parts of services, as shown below.

Service (Direct Services)
Element (Residential)
1. Component - (Detoxification)
2. Component - (Residential Treatment)
3. Component - (Recovery Home)

COST GUIDELINES. A per unit cost for alcohol services established by the Department as a standard measure for budget and cost analysis. Such costs are based on experience and periodic surveys and include a consideration for inflation.

COUNTY ALCOHOL PROGRAM ADMINISTRATOR (CAPA). Person appointed to serve as administrator of the county's alcohol program.

COUNTY ALCOHOL BUDGET (CAB). A financial plan, approved by the Board of Supervisors, which reflects the proposed means of financing a county alcohol program for a fiscal year. The budget is included as a part of the County Alcohol Plan.

COUNTY ALCOHOL PLAN (CAP). A description of planned activities and objectives for a county alcohol program for a fiscal year. Includes description of planning process, unmet needs, evaluation methodology, services and budget. The County Alcohol Plan is reviewed by the County Advisory Board on Alcohol Problems and approved by the Board of Supervisors.

DETOXIFICATION (MEDICAL/SOCIAL). Residential services, which could include medical services or prescription drugs, designed to assist acutely intoxicated individuals during the alcohol withdrawal period. Exploring plans for continued services may be part of detox. Detoxification is a direct service.

DIRECT SERVICES. Nonresidential and residential services designed to assist individuals suffering from alcohol problems to establish and maintain a recovery program. Direct service providers are required to assess and collect fees.

DROP-IN CENTER. A nondrinking environment which provides short-term alcohol services such as outreach, screening, social services, referral, meals, showers, and clean clothes. The drop-in center does not include residential detox services. It is intended to (1) serve persons using it as an alternative to jail; and (2) may serve persons who are intoxicated. This is an indirect service.

ELEMENT (SERVICE ELEMENT). A primary part of a whole. For program budget purposes, elements are primary parts of services, as shown below:

Service (Indirect Services)
A. Element - (Prevention)
B. Element - (Identification)

EMPLOYEE ASSISTANCE PROGRAM (EAP). Services designed to assist employees to recognize personal problems, including alcohol-related problems which impair job performance. These services include:

A. Intake, screening, and referral services to troubled employees (some individual counseling may occur.)
B. Development of employee assistance programs in the private or public sector.

This is an indirect service.

FACILITY. A building or specific room used to provide indirect or direct alcohol services on an average of 6 hours a day, 5 days a week, where program paid designated personnel are available.

FEES. Money paid by persons receiving services, or money paid on behalf of such persons by the Federal Government, the California Medical Assistance Program, or other public or private sources. All direct service providers shall assess and collect fees.

GROUP SESSIONS. Intensive counseling provided for two or more persons at the same time by a trained person at a facility in which the recipient of services does not reside overnight. Services in this category are directly relevant to attaining objectives in a written recovery plan. This is a direct service.

IDENTIFICATION. Activities intended to encourage those in need to seek and participate in alcohol-related services. This is an indirect service.

INDIRECT SERVICE. Community-type activities commonly referred to as "identification and prevention." These services are intended (1) to educate persons about alcohol use and to enable them to preclude or recognize their own or others' actual or potential alcohol problems; (2) to direct and make them known the availability of alcohol services; (3) to educate the community, to improve its knowledge, and to affect public attitudes and responses to alcohol problems. Indirect service providers must generate revenues.

INDIVIDUAL SESSIONS. One-to-one intensive counseling provided by a trained person at a facility in which the recipient of services does not reside overnight. Services in this category are directly relevant to attaining objectives in a written recovery plan. This is a direct service.

INFORMATION-EDUCATION. Services designed to reach and educate individuals, professionals, gatekeepers, and the general community about alcohol use and misuse and about available alcohol-related services. This is an indirect service.

INFORMATION & REFERRAL. The dissemination of alcohol-related information, including crisis intervention contacts, designed to contact and attract into services, individuals who are concerned about alcohol problems in themselves, their family, or other individuals. This is an indirect service.

INTERVENTION. See "Identification."

NONRESIDENTIAL SERVICES. Services provided in an alcohol free environment which support recovery for individuals and/or family members affected by alcohol problems. Services are performed by program designated personnel and may include the following elements: recovery sessions, educational sessions, social/recreational activities, individual and group counseling or therapy, community outreach, education and referral to other services. Volunteers may be used.

Note: Nonresidential services include drinking driver programs and vocational rehabilitation programs.

PARTICIPANT. A person for whom a county approved intake process has been completed: (1) File has been established; (2) Fee determination has been completed; (3) Plan for recovery has been developed.

PARTICIPANT VISIT. When the participant participates in a scheduled activity sponsored by the provider. A participant visit must be documented in the open file.

PREVENTION. Educational or regulatory activities intended to preclude or avert the harmful effects of alcohol use. These are indirect services.

A. Educational. Services designed to facilitate positive change in community and individual understanding, values, attitudes, and behavior concerning alcohol and inappropriate alcohol use.

B. Regulatory. Strategies designed to reduce the likelihood of inappropriate use of alcohol by developing and implementing policies designed to reduce or limit alcohol consumption.

PRIVATE ALCOHOL PROGRAM. An alcohol program operated by a nongovernmental entity.

PROVIDER. An individual, organization, or facility which provides alcohol services.

RECOVERY HOME. An alcoholic recovery home is a community-based peer-group oriented residential facility that provides food, shelter, and rehabilitation services in a supportive, nondrinking environment for mentally competent and recovering

alcoholics. Rehabilitation services provided by a recovery home shall include personal recovery planning; alcohol and recovery education; recreational activities; and information about and assistance in obtaining health, social, vocational, and other community services. This is a direct service.

RESIDENTIAL. A systematic live-in course of treatment services intended to maximize a person's ability to function without the use of alcohol.

RESIDENTIAL DAY. A unit of service defined as a person occupying a bed in a residential facility for no less than 3 and no more than 24 hours in a 24-hour period.

RESIDENTIAL TREATMENT SERVICES. The provision of food, shelter, treatment, and possibly medical services in a nondrinking, supportive environment. Residential treatment services tend to follow the medical, psychosocial approach in which degreed counseling staff or individuals with equivalent experience direct the program. This is a direct service.

SHALL, MAY, AND SHOULD. "Shall" means mandatory. "May" means permissive. "Should" means recommended.

TREATMENT SERVICES. Face-to-face and group counseling provided or facilitated by a person having specific skills in working with individuals and groups who are seeking direct assistance in resolving their alcohol problems. Treatment services are also referred to as individual and group sessions. These are direct services.

VISIT. When the individual physically enters a non-residential facility for the benefit of the supportive nondrinking environment.

2. ACRONYMS

AA	Alcoholics Anonymous
ABAP (AAB)	Advisory Board on Alcohol Problems
ASRS	Alcohol Services Reporting System
BOS	Board of Supervisors
CAB	County Alcohol Budget
CAP	County Alcohol Plan
CAPA	County Alcohol Program Administrator
DADP	Department of Alcohol and Drug Programs
DAP	Division of Alcohol Programs
EAP	Employee Assistance Program

3. ASRS PROGRAM STRUCTURE AND DEFINITIONS

The major headings in the ASRS structure (A. Administrative Services, B. Indirect Services, and C. Direct Services) are referred to as services. The subheadings (i.e., prevention or identification under Indirect Services) are referred to as an element of service. The sub-subheadings (i.e., education and regulatory under the subheading of prevention) are referred to as a component.

Reprinted from the ASRS Manual, section 5.0-5.3.

V. ASRS PROGRAM STRUCTURE AND DEFINITIONS

To provide consistency within the state's Alcohol Services Reporting System (ASRS), the Department has developed the following definitions of alcohol program services. The definitions are not intended to represent a continuum of services, nor to restrict the counties flexibility in providing services, but instead to help their planning and budget process by establishing a formal meaning for the defined services.

Counties do not have to identify each element of a provider's service, unless a particular service represents a significant portion of the provider's program. If, for example, a provider designates twenty percent (20%) or $50,000, whichever is less, of its total program cost for providing an incidental alcohol service, that service will no longer be considered an incidental service. In this case, the provider must separately identify and budget the incidental service in question. If, on the other hand, the incidental service represents less than $3,000 of total provider costs, the requirement to separately budget those incidental services is waived.

Whether a service is determined to be significant will depend on the amount of effort being devoted to it. The county plan may be flexible in determining the significance of a service. The variety of services needed within a program is an issue between providers and county administration and should not be restricted by the definition that follow.

DEFINITIONS

A. Administrative Services - County management functions including county program management, planning, monitoring, controlling, training, evaluation, and quality assurance, provided to improve the efficiency and effectiveness of county alcohol program services. Administrative Services include

1. County Program Management - The day-to-day operations of the county alcohol program generally involve county contract processes, personnel and fiscal management, technical assistance to providers, coordinating with other governmental and nongovernmental entities, and maintaining public accountability. The county alcohol program consists of all programs funded through a combination of federal, state, or county funds, or programs otherwise funded for which the County Alchol Program Administrator is responsible.

   Budgeting - The process of, and plan for, allocating resources such as manpower, facilities, equipment, materials, and service expenses during a given period against the estimated income for that period.

2. Planning - The process of deciding in advance, what to do, how to do it, and who is to do it. Planning includes needs assessment, community input, and the role of Health System Agencies in selecting county and provider's objectives as well as determining the means of reaching them.

Advisory Board on Alcohol Problems (ABAP or AAB) - An appointed body of designated community representatives who participate in the planning process and advise the county alcohol program administrator and the board of supervisors on the policies and goals of the county alcohol program.

3. Evaluation - The process of examining the results of an activity or program in relation to the attainment of goals and objectives; evaluation includes monitoring, controlling, and quality assurance.

   Monitoring/Controlling - The managerial process of securing information and taking actions to maintain or adjust program operations to meet established goals and objectives.

   Quality Assurance - A managerial process for examining a program in relation to program guidelines, goals, and objectives.

4. In Service Training - Providing job-rlated educational opportunities for program personnel and service providers involved in delivering alcohol-related services.

B. Indirect Services - Community type activities commonly referred to as "identification and prevention": (1) to educate persons about alcohol use and to enable them to preclude or recognize their own or others actual or potential alcohol problems; (2) to direct and to make known the availability of alcohol services; (3) to educate the community and to improve its knowledge, attitudes and responses to alcohol problems.

1. Prevention - Educational or regulatory activities intended to preclude or avert the harmful effects of inappropriate alcohol use.

   a. Education - Services designed to facilitate positive change in community and individual understanding, values, attitudes, and behavior concerning alcohol and appropriate alcohol use.

   b. Regulatory - Strategies for reducing the likelihood of inappropriate alcohol use which rely on developing and implementing policies designed to reduce or limit alcohol consumption.

2. Identification - Activities intended to encourage those in need to seek and use alcohol-related services.

   a. Information-Referral - The dissemination of alcohol-related information, including crisis intervention contacts, designed to contact and attract into services, individuals concerned about alcohol problems in self, family, or others.

   b. Information-Education - Services designed as outreach to educate individuals, professionals, gatekeepers, and the general community about alcohol use and misuse and about available alcohol-related services.

c. Resource Development - Activities designed to contact available staff and volunteers in human service agencies, other community organizations, and established health networks, and train them to be sensitive and responsive to alcohol use and alcohol problems.

3. Drop-In Center - A nondrinking environment which provides short-term alcohol services such as outreach, screening, social services, referral, meals, showers, and clean clothes. The drop-in center is intended to (1) serve persons using it as an alternative to jail (does not include residential detox services); and (2) serve intoxicated persons.

4. Alcohol Traffic Safety - Services (excluding state-approved drinking driver programs) designed to educate and refer those individuals who have had alcohol-related traffic violations.

5. Supplemental Security Income (SSI) - Referral monitoring services designed to treat SSI recipients who are: (1) SSA designated; (2) medically determined to be alcoholic; (3) unable to engage in substantial work because of alcoholism; and (4) participating in an approved treatment program.

6. Employee Assistance Program (EAP) - Services designed to assist employees to recognize personal problems, including alcohol-related problems which impair job performance. These services include:

   a. Intake, screening, and referral services to troubled employees (some individual counseling may occur);

   b. Development of employee assistance programs in the private or public sector.

C. Direct Services - Nonresidential and residential services designed to assist individuals and families suffering from alcohol problems to establish and maintain a recovery program. Direct service providers are required to assess and collect fees.

1. Nonresidential Services - Services provided in an alcohol-free environment which support recovery for individuals and/or family members affected by alcohol problems. Services are performed by program designated personnel and may include the following elements: recovery sessions, educational sessions, social/recreational activities, individual and group counseling or therapy, community outreach, education and referral to other services. Volunteers may be used.

   With the exception of self-help groups, participants in nonresidential services shall be assessed a fee.

   Note: Nonresidential services include drinking driver programs and vocational rehabilitation programs.

2. Residential - A systematic live-in course of environmental and/or treatment services intended to maximize a person's ability to function without using alcohol.

   a. Detoxification - A detoxification unit may be either a free-standing unit or beds specifically designated for detoxification within a facility offering other services. Detoxification services are designed to support and assist individuals during the alcohol withdrawal period, and to help them explore plans for continued services.

   b. Residential Treatment Services - Residential treatment services include the provision of food, shelter, treatment, and possibly medical services in a non-drinking, supportive environment. Residential treatment services tend to follow the medical, psycho-social approach, in which counseling staff with degrees or individuals with equivalent experience direct the program.

   c. Recovery Home - An alcohol recovery home is a community-based, peer-group oriented residential facility that provides food, shelter, and rehabilitation services for mentally competent and recovering alcoholics in a supportive, non-drinking environment. Rehabilitation services provided by a recovery home shall include personal recovery planning, alcohol and recovery eduction, recreational activities, and information about and assistance in obtaining health, social, vocational and other community services.

Appendix C

Are There Significantly Different Models of Alcohol Services?

Thomasina Borkman, Ph.D.

January 1986

In the alcohol services field in California there is extensive controversy about whether or not social models of alcohol services exist or if they are not just slightly different from professionally-based clinical models of alcohol services.

Some people have extreme opinions on both sides of the issue. Some social model advocates claim that there are no similarities between social models and clinical models. Some people on the other side claim clinical programs do everything social model do PLUS their clinical work in addition. The controversies are complicated by terminological confusion. People define "social model", "community model," "clinical model", etc. in a number of ways.

I was hired as an independent outside consultant who had no self-interest in the issue but had some knowledge of social model programs. In 1980, I conducted research on two social model alcohol programs and wrote a book about my findings that was published by NIAAA (Borkman 1983). I was asked to study a variety of county alcohol offices and their programs to identify differences in actual operational programs and to make a judgment about whether or not a distinctive "social model" was apparent in some/many programs. During the summer 1985, I collected information on 15 county alcohol administrative offices and over 58 alcohol programs in California. I visited a variety of residential programs (detoxes, recovery homes, residential treatment centers, alcohol-free living centers, hospitals), nonresidential programs (outpatient clinics, drop-in centers, community recovery centers) and "indirect services" (e.g., prevention programs, inebriate reception centers, etc.).

After the data collection and analysis, I reached several conclusions. Many people are talking past each other because they are defining social and clinical models so differently that there is little overlap. In many cases, people on one side (clinical or social model) are not familiar with the services and programs on the other side. Many people who think in terms of clinical models as social model PLUS do not believe that programs are significantly different from their clinical programs. They need to visit some social model programs to see the differences. On the other side, some social modelists are comparing themselves against hospital programs that do not seem to exist in fact anymore. They have no clear idea what clinical outpatient clinics or current hospital alcohol programs are like and need to visit some and learn about them.

Three broad definitions of social model programs can be identified (although there are many minor variations within these definitions): (1) Social Model$_1$ is the oldest/early definition that dates to the time of the Guerrero Street social setting detox and to Dr. Robert O'Briant's social alcohol program. The context then was to compare "social" with the existing form of hospital alcohol treatment or the "medical model." Social model$_1$ definition referred primarily to how these alcohol services were not medical treatment. The three major characteristics that seem to best define social model$_1$ are: (1) facility was community based, not a hospital; (2) no physician or psychiatrists diagnosed alcoholism or directed the program, and (3) no medications were used in the withdrawal process.

Many degreed or clinical people that I interviewed still use this early (and primitive) definition of social model. Many of them do not seem to be familiar with (or don't take seriously) the second definition of social model$_2$ that has developed into a social movement especially in the last 10 years.

Social model$_2$ refers to the second conceptualization that has been developed by the social/community model social movement. The movement has become particularly coherent and visible in California during the past 10 years. It is represented by (but not limited to) such leaders and spokespersons as: Dave Brown, Joe Collins, Martin Dodd, Bob Matthews, Bob Reynolds, Mary Ross, Ken Schonlau and Al Wright. Sociologically, a social movement refers to a network of persons who have banded together around similar values and interests. A movement has goals of making changes in practices, institutions and society in keeping with their values. Organizations usually develop as part of the network of relationships in a social movement (CARRH is one organization that is part of the social/community social movement). Leaders and spokespersons in a social movement are likely to have controversies, may only be a loose network of relationships and may have organizations and individuals in conflict with each other. In this case, the identifiable social/community model social movement leads in developing the concepts and practices about social/community model alcohol programs. They are the spokespersons for defining what is and what is not the social/community model alcohol program. There is far from unanimity among them as they have a number of controversies about social/community model or their practices. The network and their organizations are also politically active on the state and local levels to promulgate the interests and values of the social/community model of alcoholism.

Social/community model$_3$ refers to the third conceptualization that has been evolving within the social/community model movement especially since 1980. It will be defined later.

FINDINGS

Are there significantly different models of alcohol services? Based on my research I conclude that there are two significantly different models of alcohol services: the clinical treatment model and the social/community model.$_{2+3}$ Each is a distinct entity in its own right and stems from different histories and traditions. The models are not mutually exclusive as they have a number of elements in common (especially if you compare them with a medical hospital model).

A model is an ideal type or a conceptualization that is abstracted from reality. It defines the key characteristics of the service or program. However, it is recognized that a model is not to be found in that ideal form as such in actual operational programs. Thus, although there are definitely two models, many of the real world programs labeled a "social model" or "community model" do not have all of the defining characteristics of the social/community model. Similarly, many actual programs labeled "clinical treatment model" do not have all the defining characteristics of that model.

The clinical treatment model is defined at this point as the set of elements regarded as important professional practice in alcoholism treatment by graduate school trained and degreed (master's degrees or doctorates) professionals from such human service helping disciplines as clinical psychology, social work, marriage and family counseling that also have specific training in aloholism treatment.

The social/community model$_{2,3}$ is defined here as the concepts and practices developed and used by the social/community model social movement advocates. The advocates are those leaders and practitioners implementing and promoting programs based on that model that are part of the loose network of the social movement.

The concepts and practices of social/community models of recovery are continually evolving. Within the past five years many social model advocates have shifted their orientation and terminology from the social model of individual recovery to the community model in which the individual, family and community are targets for recovery from alcohol problems. I am uncertain whether to call the two separate models. For now I decided to regard the two as the same model for serveral reasons. First, the "community model" is newer and less familiar to many "social model"$_2$ program providers even in counties whose CAPA ascribes to the community model. The community model advocates are leaders that are ahead of their followers and they haven't educated many social modelists to become community modelists. Second, it appears that the community model includes the social model$_2$ as a subset of individual recovery. The community model expands beyond social model$_2$ to target the community and society, as needing recovery from alcohol problems. Third, it is unclear how much community model is in fact operationally separate from social model$_2$ since some people appeared to switch terminology because of mulitple definitions of social model making it a meaningless term.

Social community model$_3$ refers to the most recent conceptualization that is in process of evolving from the movement especially since 1980. The community model conceptualizes alcohol problems as involving the persons in trouble with alcohol, his family, the local neighborhood, community and the total society. In effect, permissive drinking practices, the condoning of drinking, then driving as well as many other norms and practices regarding alcohol in our society "cause" many of our alcohol problems (traffic fatalities by drinking drivers, excessive alcohol use and its consequences by "alcoholics", etc.). The community model focuses on changing norms, values, policies and practices regarding alcohol use at the level of collectivities, communities and the society.

The community model seems to subsume social model$_2$ which is primarily the means of dealing with individual recovery. Bob Matthews pointed out that the community model of alcohol problems is to social model as the public health model is to the clinical model of alcohol problems as seen in the chart below:

Focus of Analysis/ Effort	Social/Community Models	Degreed Professional Models
Individual	Social model$_2$	Clinical model
Collectivity or society	Social/community model$_3$	Public health model

Since degreed-professional models of service are legitimated and institutionalized, most people accept them readily as understandable and significant. However, for the social model$_{2+3}$ that are not widely known nor legitimated especially by degreed-professionals, these models are subject to many confusions and misinterpretations. For example, it seems clear that many degreed professionals who claim they have social model PLUS clinical programs are defining social model in its primitive terms of social model$_1$. Another possibility is that they do not know much about AA and 12 step programs which are the underlying philosophical and practical foundations of social model . Some do not believe that 12 step self-help groups involve coherent <u>involved</u> programs that teach their participants a quite different way of living than is practice in conventional middle class society. Some people trivialize 12 step programs (and by extension social model$_2$ by defining peer support in such narrow terms as emotional support, or "hand holding" and friendship. Although I feel hesitant to present a minimal set of defining characteristics of social model$_2$, I will do so with the recognition that it represents my judgment that may be modified in the future.

Minimally defining characteristics of social model$_2$ seem to include: (1) Experiential knowledge of successfully recovering alcoholics and co-alcoholics is the basis of authority in the program. (2) Primary foundation of recovery processes is the mutual aid self-help approach of 12 step programs of peers at different phases of recovery. (3) Recovery from alcoholism or co-alcoholism is viewed as a lifelong learning process (experiential in nature). (4) In the facility, there is no superordinate-subordinate counselor/therapist-client role or accompanying pharaphnalia (case files with progress notes on each client). Instead staff (while morally and legally responsible to their employing organization) are primarily recovering peers not to distinguishable from recovering participants. Staff primarily maintain a sober recovery-conducive environment rather than "managing" individual recipients of service. (5) Participants who successfully recover change from consumers to prosumers (persons who both give to others <u>and</u> receive services from others); accordingly, there is extensive volunteering among participants and alumni. (6) Participants feel they "own" the program and contribute spontaneously to its upkeep and suggest changes in services. (7) Participants, alumni, volunteers, staff, and some family and neighborhood people have relationships somewhat analogous to an extended family network. (8) Participants, alumni and volunteers (not just selected staff in specialized roles) represent the recovery center in the community giving presentations, contributing to community events, etc. The recovery facility is open to the community.

A preliminary chart listing the distinctive elements of each model and their commonalities was made. The elements listed are not exhaustive and additional elements could be added to the chart. The intention is to show that there are two different models but they also share commonalities. The social/community advocates and the clinically oriented persons seem to be both right and both wrong. There is a different social/community model which many clinically oriented people do not know or understand. On the other hand, social modelists often do not know a lot about the clinical approach and make inappropriate "straw men" comparisons. In my judgment the two models are clear and important and each should be respected in its own right.

There are actual programs that fit the social or clinical model in most key elements. Many programs I visited are hybrids and have some elements of both models. No research has been done to show what if any difference it makes in process or outcome.

Some of the differences on the chart are a matter of degree or emphasis while others are differences of kind. These distinctions are made in the phrasing of the commonalities and differences.

SOCIAL AND CLINICAL MODELS OF ALCOHOL SERVICES: DISTINCTIVE AND COMMON ELEMENTS

ELEMENTS	DISTINCTIVE ELEMENTS OF SOCIAL MODEL	COMMON ELEMENTS	DISTINCTIVE ELEMENTS OF CLINICAL MODEL
Physical environment of treatment/recovery	Home setting-living room; setting facilitates peer interaction. Ps help maintain setting.	Non-hospital. Noninstitutional; warm friendly setting	Office setting-reception desk and waiting room comfortably appointed.
View of dealing with alcohol problems.	Recovery is a lifelong process, requiring a continuous support group as reference group of sober way of life.	Alcoholism is a treatable disease.	Relatively time-limited treatment plus aftercare and follow-up is major means of dealing with problem.
Metaphor of relationships	Extended family, staff and Ps integrated, Ps become friends	No extensive distance between staff and Ps/Cs as in physician/patient relationship. Staff caring committed people.	Professional-client relationship with established boundaries. Accessibility by appointment.
Peer orientation	Peer group interaction of recovering peers at different phases of sobriety is <u>essential</u> element of recovery.	Peer oriented (recovering peers support each other)	Encourage peer support as an element of treatment.
Orientation to AA and self-help groups	12 step programs are foundation of many concepts and practices vital to social model. Educational approach to recovery.	Endorse AA; encourage Ps/Cs to participate in AA and other self-help groups. AA meetings held in facility.	Orient clients to AA for support, especially for aftercare and follow-up.

NOTE: P = Participant
C = Client

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SOCIAL AND CLINICAL MODELS OF ALCOHOL SERVICES: DISTINCTIVE AND COMMON ELEMENTS

ELEMENTS	DISTINCTIVE ELEMENTS OF SOCIAL MODEL	COMMON ELEMENTS	DISTINCTIVE ELEMENTS OF CLINICAL MODEL
Authority/knowledge Base	Experiential knowledge of recovering peers major basis of authority. Peers at various phases of recovery are role models for each other. Degreed nonrecovering staff in minority.	Experiential knowledge of recovering peers recognized as important. School-based knowledge of degreed staff recognized as important.	Professional knowledge of degreed staff major basis of authority. Degreed staff supervise (& train) other staff. Nondegreed recovering alcoholics referred to as paraprofessionals. Some recovering alcoholic staff regarded as important.
Method of learning sober like skills	Experiential learning ... learn by doing and practicing. (Action leads to attitude change, leads to learning.)		More emphasis on didactic learning; learn and then do. (Info/knowledge leads to attitude change, leads to action.)
Recovery/treatment approaches	Ps may develop recovery plan; self-help peer group emphasis on sharing experience, strength and hope; 12 step program central to recovery.	Structured program for Ps/Cs. Info/educational sessions; group sessions, social/recreational sessions. Refer Ps/Cs to vocational, medical, legal & other resources as needed.	Differential diagnosis; treatment plan developed; individual therapy; psychodynamically oriented therapy sometimes; AA or 12 step programs are adjuncts to treatment.
	Spiritual emphasis (not religious) following AA		
	Ps in Resident Council have power to screen and terminate Ps for breaking rules; Ps set many rules.	Resident Council (primarily residential programs)	Clients in Resident Council assign chores and resolve interpersonal differences.

NOTE: P = Participant
C = Client

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SOCIAL AND CLINICAL MODELS OF ALCOHOL SERVICES: DISTINCTIVE AND COMMON ELEMENTS

ELEMENTS	DISTINCTIVE ELEMENTS OF SOCIAL MODEL	COMMON ELEMENTS	DISTINCTIVE ELEMENTS OF CLINICAL MODEL
	Staff not responsible for individual's recovery; staff responsible for managing sober setting conducive to individual and peer mutual self-help.	Staff want Ps/Cs to take responsibility for their own recovery.	Counselors structure individual and group interactions to foster clients taking responsibility.
Preferred requirements for staff		Experience working in alcohol programs	
Primary	Recovery status		Degrees/credentials
Secondary	Credentials/degrees		Recovery status
Major staff role vis a vis recovery/ treatment	Maintain sober recovery conducive enironment; be recovery role model; staff do not have cases nor maintain case files especially progress notes.		Counselor, therapist or group facilitator; staff have cases, maintain files and progress notes on each client.
Ratio of recovering to degreed staff	Recovery staff in majority		Degreed staff in majority
Attitude toward volunteers	Volunteer opportunities developed to give recovering peers chance to do service to feel good about themselves following 12 step principles. Volunteers substitute for staff and dealt with as paid staff.	Volunteers are useful and contribute to the program.	Volunteers adjuncts but not substitutes for staff. Volunteers used selectively.

NOTE: P = Participant
C = Client

Thomasina Borkman, Ph.D.
Revised January 1986

SOCIAL AND CLINICAL MODELS OF ALCOHOL SERVICES: DISTINCTIVE AND COMMON ELEMENTS

ELEMENTS	DISTINCTIVE ELEMENTS OF SOCIAL MODEL	COMMON ELEMENTS	DISTINCTIVE ELEMENTS OF CLINICAL MODEL
Some prized values	Rigorous honesty a la AA. Interdependence (mutual aid & self-help). Strength through vulnerability. Valuing increased involvement over efficiency of operation.	Ps/Cs take responsibility for recovery. Compassion for persons affected by alcohol problems. Staff respect Pc/Cs and serve them with dignity.	Professionalism: efficiency of operation; specialization; client achieving independence and insight.
Community orientation	Public info/education generally integrated with recovery activities; Demonstration of Ps recovery & prevention are two sides of the same coin. Ps do services for/in community. Wide variation in whether "community model" oriented.	Public info/education (prevention) is important. 1985-prevention broadened conceptually to include media, public policy, and community organization.	Public info/education generally separated from treatment activities. Wide variation in whether "public health model" oriented.
Record keeping	Encourage Ps to complete their own recovery plan. Deemphasize case records on each P, especially no progress notes by staff since they have no cases. Keep records on group activities, not progress notes on Ps.	Comply with federal, state & county record keeping requirements. Maintain internal set of records useful for program.	Emphasize appropriate, complete & accurate case file with progress notes on each client following accepted professional practice; case records critical toll to manage client case; case reviews done to show quality of program; progress notes important indicator of counselor's competence.

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SOCIAL AND CLINICAL MODELS OF ALCOHOL SERVICES: DISTINCTIVE AND COMMON ELEMENTS

ELEMENTS	DISTINCTIVE ELEMENTS OF SOCIAL MODEL	COMMON ELEMENTS	DISTINCTIVE ELEMENTS OF CLINICAL MODEL
Terminology	Recovery; participant, resident, guide	Federal/state terms tied to funding	Treatment, therapy, client, counselor, case record
Principles for intergrating various services	Generalists; maximize combining of services into one program; involve peers at different stages of recovery together	Federal/state funding requirements and standards	Specialization; complex division of labor (team approach) with coordination. Separate functional services into specialized programs.
Indicators of high quality programs	Extended family-like network of relationships; "loving accepting setting". Ps "own" program & contribute spontaneously to it. High rate of volunteerism, alumni return to interact with newly recovering; mutual aid but do-it-yourself. Ps, alumni or staff initiate or refine services as needs surface or change.	Staff believe that a high percentage Ps/Cs achieve sobriety in their program. Ps/Cs develop sober lifestyle, become self-supporting and grow as persons. Staff satisfied with results of Ps/Cs. Staff satisfied with their work.	Procedures, policies, programs & cases well documented in written form following professional standards. Well trained well supervised staff; case file records of clients complete & follow professional standards; produce adequate units of service according to reporting systems.

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Appendix D

THE COMMUNITY-SOCIAL MODEL PHILOSOPHY

Two excerpts from the Alameda County Alcohol Plan (1983-1984) are presented. First, the community-social model philosophy is described in the narrative section of the county plan for fiscal year 1983/84, pp. 2-10. This presentation of the philosophy illustrates how CAPA's use the CAP for educational purposes.

Second, a section "Services that Comprise the County Alcohol Program" (pp. 14-16), describes how and why the indirect and direct ASRS services categories do not fit the comm-soc model philosophy.

ALAMEDA COUNTY PLAN FOR ALCOHOL-RELATED PROBLEMS

Fiscal Year 1983/84

NARRATIVE SECTION

Overview of the County System

Introduction

The goal of Alameda County's alcohol program is to reduce denial of alcoholism and other alcohol-related problems at the individual, family, and community levels. Alameda County recognizes that alcohol problems are not merely individual problems. They are also social problems. Addiction to the drug alcohol, although physiological, is at least in part caused by participation in a highly valued and visible social custom. However, because of the many historical, social, economic, and public policy factors which actively promote heavy drinking in our society, recognition of the magnitude of the alcohol problems around us remains very limited.

Alcohol problems are most often defined in terms of their impact on individuals. This approach has been useful in helping to direct recovery services to people in crisis. However, it has limited the amount of attention which must be directed to the family and society in order to affect the problem significantly.

In most regions of the United States, the degree or magnitude of alcohol problems is defined simply in terms of the number of problem drinkers in the region. Stating the problem in these terms strongly influences the response: there is a need to provide recovery services for a given number of problem drinkers. While that approach may be a useful first step, it does not provide adequate recognition of the societal and public policy factors which contribute significantly to the creation of alcohol problems.

Most efforts in the past have focused on providing treatment for individuals and educational efforts designed to change knowledge and attitudes at the family and community level. In spite of these efforts, the severity of alcohol-related problems has increased. Studies over two decades in several countries have demonstrated that alcohol-related health problems are closely tied to the mean per capita alcohol consumption of a community or society of drinkers. As the average per capita consumption increases, alcohol-related health problems increase (Wittman, 1982).

Alcoholism, seen in its broadest context, is a community illness. Those individuals who are physiologically addicted to the drug represent only a part of the full scope and severity of alcohol problems in the United States. Therefore, our responses to alcohol problems must be extended beyond the provision of recovery opportunities for the increasing number of individuals who may be considered alcoholic. Efforts must be made to reduce the incidence of all alcohol problems at the family, societal, and public policy levels.

Alcohol problems occur as a result of the interaction of many factors and require a complex solution--a solution which encompasses intervention at the individual, family, and societal levels and which is based on the combined efforts of many segments of our society. Factors contributing to alcohol problems identified in the fiscal year 1983/84 planning session process include attitudes toward the role of alcohol in our society as reflected in the media, the manner in which alcohol beverages are advertised and otherwise marketed, public policies regarding availability of the drug, and social values regarding the nature and use of the drug.

Recovery from alcoholism and other alcohol-related problems begins with a decision to not participate in the widely accepted social custom of drinking. We are well aware of the alcoholic's "reasons" for drinking: pressure on the job, marital problems, financial troubles, arthritis, bursitis and sinusitis, to name only a few. We know that these reasons are in fact excuses. We know, too, that the alcoholic must come to terms with his or her denial as the first step in recovery. The alcoholic must first recognize the "reasons" as excuses. The drinking must stop before any of the alcoholic's other problems can be addressed. But what about the rest of us?

We are equally well aware of the many social occasions where the use of alcohol is not only usual, but expected. The heavy use of large amounts of alcohol at weddings, office Christmas parties, boat launchings, christenings, funerals, fourth of July picnics, and other occasions is a well-established societal norm. Seen in the context of community alcoholism, along with our concern about uncritical and often indiscriminate use of alcohol, these social occasions may be little different from the alcoholic's reasons. Society's occasions, similar to the alcoholic's reasons, may, in some sense, be seen as excused. And, as with the alcoholic, the community must come to terms with its denial. Rather than assuming the presence and use of alcohol, social norms should be developed which encourage critical examination of the uses of alcohol which might be considered appropriate in varying social situations.

Community Alcoholism and Strategies for Reducing Alcohol-Related Problems

It is the drug alcohol which causes alcohol-related problems. A major obstacle to reducing alcohol-related problems is the fact that alcohol is generally seen as a socially accepted and highly valued beverage. A major focus of programs designed to reduce alcohol-related problems must be, therefore, to raise the general societal awareness of alcohol as a drug. The fact is that alcohol is a dangerous and potentially deadly drug. Dr. Lawrence Wharton, in his article "The American Way of Drinking and Drugging," illustrates this point:

> The active ingredient in all alcoholic beverages has the chemical formula: C_2H_5OH. The conclusion that alcohol is a drug is supported by the fact that when two alcohol molecules are joined chemically by the removal of one water molecule, the chemical result is ether...Even though we think of alcohol as a beverage, it is, in fact, a pure sedative drug...(CJER Journal, 17, 1979.)

There are very few people who would see an invitation for a few friends to get together for the purpose of inhaling some ether as anything short of absurd. With the replacement of that single molecule of water, however, we have created the primary ingredient of the time-honored cocktail party.

Community alcoholism is the indiscriminate distribution and use of the drug alcohol. Community denial is society's disguising of the drug as a beverage.

Symptoms of community alcoholism are all too easily identified. We should consider, for example, the implications of very young children learning the catchy and uplifting theme songs for various brands of beer while enjoying the "national pass time" of baseball on television. Our society is rightfully indignant about the daily toll taken on our health and lives by people who drive after using the drug alcohol. Little thought is given, though, to

the sale of alcohol to the millions of people who drive to and from our sports arenas, opera houses, and other recreational areas. We are quick to denounce "the drug problem" when we see the rampant use of marijuana, cocaine, quaaludes, and other pills in our schools. However, we too often gather over cocktails or or the neighborhood bar to discuss "the drug problem."

The notion of alcoholism as a community illness postulates a reciprocal relationship between the individual and the society in which he or she functions. While we recognize that abstinence from alcohol is necessary to recover from individual alcoholism, our society strongly encourages alcohol use in many situations. The person who chooses not to drink at all is viewed as socially deviant. The community concept dictates that to treat alcoholism effectively, we must not only deal with each individual problem drinker, but with the family, the surrounding social unit, and the community at large.

A premise essential to the community concept is that alcoholism is a condition located both in the individual and in the community, rather than in the individual alone. The condition is characterized in the individual by a dependency on alcohol resulting in alienation, loss of self-esteem, role dysfunction, and an irreversible inability to safely ingest any amount of alcohol. The condition is characterized in the community by responses and practices creating social pressures to drink. The condition is also characterized by individual and community denial that alcohol is a drug.

For individuals, alcohol is such a debilitating drug that prolonged, heavy drinking is impossible without support from other people. This support (almost always unintentional) often comes from family members, employers, co-workers, social workers, government agencies whose purpose it is to help people in distress, and well-meaning friends. If support from the surrounding social unit could be entirely removed, most alcoholic drinking would have to stop. Thus, program efforts must be aimed at extinguishing the dependent role which the alcoholic assumes. These efforts should bring about an interruption of the reciprocal relationship between the drinker and the surrounding social unit.

The same principles may be applied to community alcoholism. If support, however unintentional, for indiscriminate, heavy use of alcohol in various social situations could be reduced, most alcohol-related problems could be prevented. If support for alcohol advertising featuring sex, youth, and success could be removed, the false glamour currently associated with alcohol use would be reduced; enabling a more realistic assessment of the appropriate place for the drug in our social lives. Thus, program efforts must be aimed at creating an environment in which sobriety is the norm and within which alcohol would be used only in an informed and critical way.

The Alameda County ad hoc planning task force for FY 1982/83 recognized that meaningful efforts to reduce alcohol-related problems must include strategies to reduce per capita consumption of alcoholic beverages. Working from this premise, the task force for FY 1983/84 recommended that these strategies should be a major focus of the activities of community recovery centers. Recovery centers, therefore, should develop activities focused on the entire social context of drinking, rather than on limited areas such as preventing alcoholism or providing individual recovery services or developing special services for specific groups. The planning task force has recommended that model contract objectives for community recovery centers include such things as a school poster contest, a coffee-tasting event, door-to-door neighborhood canvassing, local park clean-ups, an alcohol-free Superbowl party, and an "It's OK not to drink" media campaign.

Seen in its broadest context, alcoholism is a social disease. Community recovery centers are, therefore, primarily oriented toward systemic rather than ameliorative change. A primary goal of all recovery programs is to create an environment conducive to recovery for the entire community. In order to effectively address the entire social context within which drinking occurs, a significant amount of program activity must be devoted to altering the surrounding community.

Community recovery centers provide a variety of activities designed to address individual, family, and community aspects of alcohol problems. All of these activities are based upon the overriding assumption that it's O.K. not to drink. Within a general social climate that encourages the use of alcohol, community recovery centers provide an altered community within which sobriety is the norm. This principle applies to both nonresidential recovery centers as well as residential recovery centers. The difference between the two types of centers is that the residential programs also provide a place to live for those people who need such a service.

A major effort of all community recovery centers should be to raise the awareness of problems related to the use of the drug alcohol in the minds of all citizens of the county. A major measure of success would be the extent to which every person in Alameda County would ask themselves, prior to taking a drink, "Why am I having this drink?"

The use of alcohol in our society is so pervasive that most people drink without thinking. Program activities designed simply to raise the question "When, if ever, is it appropriate for me to use alcohol?" will go a long way toward reducing alcohol-related problems. In a very real way, the mere asking of the question is a major step toward the solution of the problem. In order to assist people in this process, recovery centers offer extensive on-site education on the nature of alcohol as a drug, the effects of alcohol on the body, and information on the progressive nature

of individual, family, and community alcoholism. These activities are all conducted in a drug-free environment in which people may socialize and support one another in their mutual concerns.

Although the community center concept broadens our perspective to include alcoholism as a social illness, recovery centers continue to provide much needed services for individuals whose personal drinking has already become unmanageable, and for whom the use of alcohol has become an addiction. Recovery centers, therefore, may include detoxification services for people who have stopped drinking and need special support during the initial phases of withdrawal. They also provide physical space for meetings of Alcoholics Anonymous and other peer-oriented support and problem-solving groups. The important residential services of the traditional alcoholic recovery home may also be part of the activities of a community recovery center.

Drinking and Driving

The issue of drinking and driving is perhaps the most dramatic example of alcoholism as a social illness as well as an individual disease. The problem of driving under the influence has historically and traditionally been seen as a traffic safety problem. This problem is all too often approached in terms of strategies designed to "rid the highways of those drink drivers." Drinking and driving is, however, as much a social problem as it is a personal behavior. Public policies support drinking and driving in many subtle ways. At any major league baseball stadium (and, in fact, at many college and high school games), we find thousands of people consuming gallons of beer. Most of them will drive home. Consider a reststop on Interstate 5:"cocktail lounge," "liquor," "cold beer" are the prominent enticements. Everyone who stops there will continue driving after "resting up." As we drive into the local gas station, the price of gasoline seems less significant compared to the bargain price for beer sold at the same establishment. We should not merely blame "drunk drivers." Whether we call it drunk driving, the problem of drinking and driving, or driving under the influence, this is an issue which involves all of us. As Pogo said, "We have met the enemy and he is us."

Once again, the challenge for community recovery centers is to raise the level of awareness regarding the appropriateness of the use of alcohol in the context of the use of the automobile. Although each of the drinking and driving programs in Alameda County provide services to individuals who have been convicted of driving under the influence and referred by sentencing courts, the overall goals of these programs are much broader. All of the drinking and driving program efforts in Alameda County are designed to assist each resident of the county to critically examine his or her behavior and beliefs about drinking and driving. In order to affect meaningful and lasting change in these areas, program activities must be designed which will

initiate public discussion and critical examination of our drinking and driving society. Why, for example, are so many on-site establishments located in areas accessible only by automobile? Or, is it appropriate for the state law regarding driving under the influence to limit criminal prosecution to persons whose blood alcohol content has reached .10% when we know that even small amounts of alcohol have an effect on our judgment and motor skills?

An ongoing task of the county alcohol program is to coordinate efforts between the public and private sectors to continue to critically examine norms and policies which, however unintentionally, contribute to increasing levels of drinking and driving behavior.

Services That Comprise the County Alcohol Program

Introduction

As suggested earlier, alcoholism is both a personal and a social disease. It is a condition located in the individual and in the community, not in the individual alone. The Alameda County plan for alcohol-related problems defines all alcohol problems as symptoms of this personal/social disease. Denial is probably the single most powerful symptom of alcoholism. In the absence of an elaborate denial system, both individuals and society at large would cease to tolerate the enormous human and economic costs incurred through the indiscriminate use of the drug alcohol. This is why the alcohol programs in Alameda County do not focus on the individual to the exclusion of the community. Instead, alcohol services in Alameda County focus on the community as a whole and seek to provide an environment supportive of recovery both for individuals who are suffering from the excessive use of alcohol, and for the community whose symptom is denial.

Given this analysis of the problem, the service definitions contained in the Alcohol Services Reporting System (ASRS) Manual, developed by the state Department of Alcohol and Drug Programs, are difficult to apply. The manual's definition of direct services, with minor changes, could describe many of the activities performed by the county alcohol program administrative staff as well as those activities performed by the alcohol program contractors. For example, Alcohol and Drug Services administrative staff may provide information for a news story on drinking and driving. This effort addresses the aspect of community denial which limits the definition of drinking and driving to the perspective of traffic safety. Within the context of the community model, this is a direct service.

The great majority of Alameda County's alcohol program effort goes into the provision of nonresidential and residential services designed to assist individuals, families, and the community at large--all of whom suffer from alcohol problems--to establish and maintain a recovery program. However, many of the specific techniques that we use to do this are described by ASRS as part of the definition for indirect services.

It appears that a clear distinction between direct and indirect services can be maintained only if alcoholism is defined purely as an individual disease. That is, some people have it and some do not have it. Within this conceptual framework, indirect services are those activities designed to identify the people who have alcoholism so they can be assisted to recovery through direct services.

Throughout this discussion, we have illustrated that everyone suffers from alcoholism--either from the personal disease or the social illness. Activities designed to raise the community's awareness of alcoholism as a social and personal disease from which everyone suffers are frequently the same activities we perform in an effort to support individual recovery. Under these circumstances, direct and indirect services become undistinguishable.

A dance at a community recovery center will illustrate how difficult it is to categorize community model program activities in the terms defined by ASRS. The dance is planned by staff and volunteers. Donations of money, decorations, and refreshments are solicited from local businesses. In the process, community business people learn about the services available through the center. Flyers are distributed throughout the neighborhood, inviting people to the dance and briefly describing the program's activities. On the night of the dance, participants from a local residential program, along with many of their family members, are among those present. A group of high school students is attracted by their favorite local band. They dance and enjoy the environment, including the festive non-alcoholic beverages. A member of the county alcohol division attends as part of informal program monitoring. She dances a few dances and has several conversations with other guests about the center and other alcohol programs funded by the county. On the morning after the dance, a group of center volunteers put on their center jackets, with the recovery center logo printed brightly on the back, and go out to pick up any paper cups or other trash that may have been left behind by their guests. Neighbors who live in the area, as well as drivers in passing cars, observe the volunteers as they clean up around the center.

In the community model approach to alcohol problems, the dance is much more than recreation. The planning, publicity, the event itself, as well as the clean-up afterwards are each parts of a process addressing alcohol problems at the individual, family,

and community levels. Involvement in planning the dance provides tangible support for the recovery process of individuals by giving them an opportunity to work with others in a creative effort. The recovery of families is supported through the experience of family fun in an alcohol-free environment. Members of the community at large have contact with the center through publicity, the dance itself, and the clean-up after. This contact gives information about the program services, demonstrates fun without alcohol, establishes the center and participants as a contributing part of the community, and provides an opportunity for local businesses to support the program. The ASRS manual would define the activities involved with this event as indirect services. In terms of the community model of alcohol problems, however, these are all direct services.